Washington State Department of
Labor & Industries
Workers' Compensation Services

Payment Policies

for Services Provided to Injured Workers
and Victims of Crime

Effective July 1, 2008

This document is also on the department's Internet web site at http://feeschedules.lni.wa.gov/.

Updates to this manual can be found under 'Updates and Corrections' tab on the department's Internet web site at http://feeschedules.lni.wa.gov/

Updates to this manual are also announced on the Medical Provider e-News listserv. Individuals may join the listserv at http://www.lni.wa.gov/Main/Listservs/Provider.asp.

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How to Use This Manual

The *Medical Aid Rules and Fee Schedules* manual consists of several sections. Below are some tips on how to find the information you need.

SPECIFIC SECTIONS WITHIN THIS MANUAL

- Introduction – contains general policies that all providers need.
- Professional – contains information for individual professional providers.
- Facility – contains information necessary for facility providers.
- Appendices – contains compilation of coverage information pertaining to all sections.

SPECIFIC SECTIONS NOT CONTAINED WITHIN THIS MANUAL

- Fee Schedules – contains the fees associated with authorized billing codes.
- Field Key – contains the column headings and abbreviations for the Fee Schedules.
- Medical Aid Rules – contains L&I specific Washington Administrative Code (WAC).
- Updates and Corrections – contains any updates to policies and fees.
  - http://feeschedules.lni.wa.gov/.

TO NAVIGATE THROUGH THIS MANUAL

- The Table of Contents – The page numbers are links to the page.
- The Index – The page numbers are links to the page.
- The **Bookmarks** tab (see the far left of this manual.) is a feature of Adobe Acrobat. You can use the bookmark links to jump around this manual. If the Bookmark tab is not open you can open it by clicking on the **Bookmarks** tab.
  - Click on any text in the list to go to the information within this manual.
  - Click on the plus (+) sign to open each section's list for more information.
  - Click on the minus (-) sign to close the section.
- The Binocular Search icon is another feature of Adobe Acrobat.
  - Follow the instructions to search for the item or topic you need.
- To search for a word, Press 'Ctrl+F'.
  - Follow the instructions to search for the item or topic you need.
- Use the two kinds of hyperlinks within this manual:
  - Internal jump links are similar to the bookmark links mentioned above.
  - Internet web sites always begin with http:// - These links will take you to the internet web site.

TO FIND INFORMATION ON A SPECIFIC PROCEDURE CODE

- Review the payment policy, (which is inside this manual).
- Review the fee schedule, (which is outside of this manual).

TO PRINT INFORMATION WITHIN THIS MANUAL

- Use the Print icon which is on the same menu as the Binocular Search icon.
  - This print feature will give you options specific to printing this Adobe Acrobat file (PDF) which allows you to print a specific page or the entire manual.

Highlights of Changes

This Medical Aid Rules and Fee Schedules (fee schedule) is effective for services provided on or after July 1, 2008. These highlights are intended for general reference; they are not a comprehensive list of all the changes in the fee schedule. Refer to the 2008 CPT© and HCPCS coding books for complete code descriptions and lists of new, deleted or revised codes.

WASHINGTON ADMINISTRATIVE CODE (WAC) AND PAYMENT CHANGES

- Cost of living adjustments were applied to RBRVS and anesthesia services and to most local codes.
- WAC 296-20-135 increased the RBRVS conversion factor from $56.38 to $61.53 and increased the anesthesia conversion factor from $3.08 per minute ($46.20 per 15 minutes) to $3.19 per minute ($47.85 per 15 minutes).
- WAC 296-23-220 and WAC 296-23-230 increased the maximum daily cap for physical and occupational therapy services to $118.07.
- WAC 296 -23 –250 set a daily cap of 75% of the daily cap for PT/OT services. The rate for July will be $88.55.

POLICY & FEE SCHEDULE ADDITIONS, CHANGES AND CLARIFICATIONS

Introduction

- Providers may use their National Provider Identifier (NPI) to bill L&I once the NPI number has been registered with L&I.

Professional Services

- Coding for team conferences, telephone calls and online communications has been completely revised but L&I is not following AMA guidelines for the use of the codes.
- A new example has been added to the Endoscopy section to clarify payment when a surgical procedure has the highest fee.
- Clarifications were made to the chiropractice IME payment policies.
- Psychiatric treatment guidelines contained in the Office of the Medical Director's Treatment Guidelines were removed from the fee schedule.
- A new Dental payment policy section has been added to MARFS.
- The Home Health Services section has been revised and new codes have been added.
- The Audiology section contains a new policy for the replacement of linear analog hearing aids.
- Non-injectable medication policy was changed showing that miscellaneous oral medication dispensed from the physician's office is bundled.

Facility Services

- Hospital AP-DRGs have been changed to version 23 from version 21.
- Ambulatory Surgery Center payment method has been completely revised.
- Fees including Hospital AP-DRG and Per Diem rates, Residential facilities, Brain Injury Programs, Pain Management Programs and Ambulatory Surgery Centers have been updated.

Appendices

- Preferred Drug List has been updated.
- Other appendices have been updated with new codes

Fee Schedules

- With the exception of the comma delimited files, the Field Keys have been integrated into the fee schedules.
- Professional fees have been updated.
- Hospital AP-DRG outlier thresholds have been updated with the new AP-DRG version.
- Ambulatory Surgery Center fees have been completely changed.
- Hospital percent of allowed charge (POAC) factors have been updated.
- Hospital rates have been updated.
- Hospital ambulatory payment classification (APC) rates have been updated.
- Residential fee schedule has been updated.

Introduction

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS), and Provider Bulletins. If there are any services, procedures or text contained in the physicians' Current Procedural Terminology (CPT®) and federal Healthcare Common Procedure Coding System (HCPCS) coding books that are in conflict with MARFS, L&I's rules and policies take precedence (WAC 296-20-010). All policies in this manual apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

For more information on L&I WACs go to
http://www.LNI.wa.gov/ClaimsIns/Rules/MedicalAid/default.asp

For more information on the Revised Code of Washington (RCW) go to
http://search.leg.wa.gov/pub/textsearch/default.asp

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

EFFECTIVE DATE

This edition of the Medical Aid Rules and Fee Schedules (MARFS) is effective for services performed on or after July 1, 2008.

UPDATES AND CORRECTIONS TO THE FEE SCHEDULES

If necessary, corrections to MARFS will be published on L&I's web site at http://feeschedules.lni.wa.gov/ under Fee Schedules/Updates & Corrections.

Additional fee schedule and policy information is published throughout the year in L&I's Provider Bulletins that are available at http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp

Interested parties may join the L&I Medical Provider News electronic mailing list at http://www.lni.wa.gov/Main/Listservs/Provider.asp

Listserv participants will receive via e-mail:

- Updates and changes to the Medical Aid Rules and Fee Schedules.
- A link to the new Provider Bulletins as soon as they are posted.

STATE AGENCIES' FEE SCHEDULE AND PAYMENT POLICY DEVELOPMENT

Washington State government payers coordinate fee schedule and payment policy development. Billing and payment requirements are as consistent as possible for providers.

The state government payers are:

- The Washington State Fund Workers' Compensation Program administered by the Department of Labor and Industries (L&I).
- The Uniform Medical Plan administered by the Health Care Authority (HCA) for state employees and retirees.
- The State Medicaid Program administered by the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS).

These agencies comprise the Interagency Reimbursement Steering Committee (RSC). The RSC receives input from the State Agency Technical Advisory Group (TAG) on the development of fee schedules and payment policies. The TAG consists of representatives from almost all major state professional provider associations.

While the basis for most of the agencies' fee schedules is the same, payment and benefit levels differ because each agency has its own funding source, benefit contracts, rates and conversion factors.

PAYMENT REVIEW

All services rendered to workers for L&I claims are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

HEALTH CARE PROVIDER NETWORKS

The Revised Code of Washington (RCW) and the Washington Administrative Code (WAC) allow L&I and self-insured employers (collectively known as the insurer) to recommend particular providers or to contract for services. Workers are responsible for choosing their specific provider. RCW 51.04.030 (2) allows the insurer to recommend to the worker particular health care services or providers where specialized or cost effective treatment can be obtained. However, RCW 51.28.020 and RCW 51.36.010 stipulate that the worker is to receive proper and necessary medical and surgical care from licensed providers of his/her choice.

MAXIMUM FEES NOT MINIMUM FEES

L&I establishes maximum fees for services; it does not establish minimum fees.

RCW 51.04.030 (2) states that L&I shall, in consultation with interested persons, establish a fee schedule of maximum charges. This same RCW also stipulates that no service shall be paid at a rate or rates exceeding those specified in such fee schedule. WAC 296-20-010(2) reaffirms that the fees listed in the fee schedule are maximum fees.

BECOMING A PROVIDER

WORKERS' COMPENSATION PROGRAM

Providers must be an active L&I provider and have an active L&I account number to receive payment for treating Washington workers. This proprietary account number is necessary for L&I to accurately set up its automated billing systems. The provider's federally issued National Provider Identifier (NPI) may be used to bill L&I once the L&I number is established and the NPI is registered with L&I. Either the L&I account number or the NPI can be used with bills and correspondence submitted to L&I. All L&I providers must comply with all applicable state and/or federal licensing or certification requirements to assure they are qualified to perform services. This includes state or federal laws pertaining to business and professional licenses as they apply to the specific provider's practice or business.

Providers can apply for L&I account numbers by completing a Provider Account Application (form F248-011-000) and Form W9 (form F248-036-000). These forms are available at http://www.becomeprovider.lni.wa.gov or can be requested by contacting L&I's Provider Accounts section or the Provider Hotline. Providers can apply for the NPI at https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Contact Information

Provider Accounts
Department of Labor & Industries
PO Box 44261
Olympia, WA 98504-4261
360-902-5140

Provider Hotline
1-800-848-0811

More information about the provider application process is published in WAC 296-20-12401.

KEEP YOUR PROVIDER ACCOUNT UPDATED

Keep us informed of your account changes to prevent payment delays by completing a Provider Accounts Change Form (form F245-365-000). Providers with active L&I accounts are listed on Find-a-Doctor at https://fortress.wa.gov/lni/fad/.

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to: http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

CRIME VICTIMS COMPENSATION PROGRAM

Providers treating crime victims must apply for a separate provider account with the Crime Victims Compensation Program. Provider Applications (form F800-053-000) and Form W9 (form F800-065-000) for the Crime Victims Compensation Program are available on L&I's web site at http://www.lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp or can be requested by contacting the Crime Victims Compensation Program.

Contact Information

Crime Victims Compensation Program
Provider Registration
Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
1-800-762-3716

BILLING INSTRUCTIONS AND FORMS

BILLING PROCEDURES

Billing procedures are outlined in WAC 296-20-125.

BILLING MANUALS AND BILLING INSTRUCTIONS

The *General Provider Billing Manual* (publication F248-100-000) and L&I's provider specific billing instructions contain billing guidelines, reporting and documentation requirements, resource lists and contact information. Providers can request these publications from L&I's Provider Accounts section or the Provider Hotline. (See the Becoming a Provider section above for contact information.)

BILLING FORMS

Providers must use L&I's most recent billing forms. Using out-of-date billing forms may result in delayed payment. To order new billing forms or other L&I publications, complete the "Medical Forms Request" (Form F208-063-000) (located under Contact Information on the MARFS CD or on L&I's web site at http://www.lni.wa.gov/Forms/pdf/208063a0.pdf and send it to L&I's warehouse (address listed on the form). You may also download many forms from L&I's web site at http://www.lni.wa.gov/FormPub/.

GENERAL BILLING TIPS

This symbol is placed next to billing tips throughout the policy sections to facilitate correct payments.

SUBMITTING CLAIM DOCUMENTS TO THE STATE FUND

Submitting State Fund bills, reports and correspondence to the correct addresses helps L&I pay you promptly.

NOTE: Attending providers have the ability to send secure messages through the Claim and Account Center at http://www.lni.wa.gov/ORLI/LoGon.asp.

Item	FAX Numbers	State Fund Mailing Address
Report of Industrial Injury or Occupational Disease – Accident Report F242-130-000	ROAs ONLY (360) 902-6690 (800) 941-2976	Department of Labor & Industries PO Box 44299 Olympia, WA 98504-4299
Correspondence, Activity Prescription Forms, reports and chart notes for State Fund Claims and claim related documents other than bills.	(360) 902-4292 (360) 902-4565 (360) 902-4566 (360) 902-4567 (360) 902-5230 (360) 902-6100 (360) 902-6252 (360) 902-6460	Department of Labor & Industries PO Box 44291 Olympia, WA 98504-4291 **Reports and chart notes must be mailed separately from bills.**
State Fund Provider Account information updates	(360) 902-4484	Department of Labor & Industries PO Box 44261 Olympia, WA 98504-4261
UB-04 Forms CMS 1500 Forms Retraining & Job Modification Bills Home Nursing Bills Miscellaneous Bills Pharmacy Bills Compound Prescription Bills Requests for Adjustment		Department of Labor & Industries PO Box 44269 Olympia, WA 98504-4269
State Fund Refunds (attach copy of remittance advice)		Cashier's Office Department of Labor & Industries PO Box 44835 Olympia, WA 98504-4835

TIPS FOR SUBMITTING DOCUMENTS TO THE STATE FUND

The State Fund uses an imaging system to store electronic copies of all documents submitted on workers' claims. This system cannot read some types of paper and has difficulty passing other types through automated machinery.

Do's

These tips can help L&I process your documents promptly and accurately.

- Put the patient's name and claim number in the upper right hand corner of each page.
- Submit documents on white 8 ½ x 11-inch paper (one-side only).
- Leave ½ inch at the top of the page blank.
- Submit legible information.
- If there is no claim number available, substitute the patient's social security number.
- Emphasize text using asterisks or underlines.
- Staple together all documents pertaining to one claim.
- Include a key to any abbreviations used.
- Reference only one worker/patient in a narrative report or letter.

Don'ts

Please **do not**:

- Use colored paper, particularly hot or intense colors.
- Use thick or textured paper.
- Send carbonless paper.
- Use any highlighter markings.
- Place information within shaded areas.
- Use italicized text.
- Use paper with black or dark borders, especially on the top border.
- Staple documents for different workers/patients together.

Following the above tips can prevent significant delays in claim management and bill payment and can help you avoid repeated requests for information you have already submitted.

DOCUMENTATION REQUIREMENTS

Providers must maintain documentation in workers' individual records to verify the level, type and extent of services provided to workers. The insurer may deny or reduce a provider's level of payment for a specific visit or service if the required documentation is not provided or the level or type of service does not match the procedure code billed. No additional amount is payable for documentation required to support billing.

Providers can submit forms with a signature stamp or an electronic signature from the medical provider. L&I **will not pay** for forms unless they are signed by the provider.

In addition to the documentation requirements published by the American Medical Association (AMA) in the CPT® book, the insurer has additional reporting and documentation requirements. These requirements are described in the provider specific sections of this document (MARFS) and in WAC 296-20-06101. The insurer may pay separately for specialized reports or forms required for claims management. For specific documentation requirements see **Appendix G**.

RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with L&I, you are the legal custodian of workers' records. You must include subjective and objective findings, records of clinical assessment (diagnoses), reports, interpretations of X-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for L&I to audit the provision of services for a minimum of 5 years (See WAC 296-20-02005).

Providers are required to keep all X-rays for a minimum of 10 years (See WACs 296-20-121 and 296-23-140).

CHARTING FORMAT

For charting progress and ongoing care, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format.

In workers' compensation there is a unique need for work status information. To meet this need L&I suggests that you add **ER** to the SOAP contents.

Chart notes must document:

E Employment issues

Has the worker been released or returned to work?

When is release anticipated?

Is the patient currently working, and if so, at what job?

Include a record of the patient's physical and medical ability to work.

Include information regarding any rehabilitation that the worker may need to undergo.

R Restrictions to recovery

Describe the physical limitations (temporary and permanent) that prevent return-to-work.

What other limitations, including unrelated conditions, are preventing return-to-work?

Are any unrelated condition(s) impeding recovery?

Can the worker perform modified work or different duties while recovering (including transitional, part-time, or graduated hours)?

Is there a need for return-to-work assistance?

SOAP-ER CHARTING FORMAT

Office/chart/progress notes and 60-day narrative reports should include the SOAP contents:

S Worker's Subjective complaints

What the worker states, or what the employer, co-worker or significant other (family, friend) reports, about the illness or injury. Refer to WAC 296-20-220 (j).

O Objective findings

What is directly observed and noticeable by the medical provider. This includes factual information, for example, physical exam – skin is red and edematous, lab tests – positive for opiates, X-rays – no fracture. Refer to WAC 296-20-220 (i).

A Assessment

What conclusions the medical provider makes after evaluating all the subjective and objective information. Conclusions may appear as

- A definite diagnosis (dx.),
- A "Rule/Out" diagnosis (R/O), or
- Simply as an impression.

This can also include the etiology (ET), defined as the origin of the diagnosis; and/or prognosis, defined as being a prediction of the probable course or a likelihood of recovery from a disease and/or injury.

P Plan and Progress

What the provider recommends as a plan of treatment. This is a goal directed plan based on the assessment. The goal must state what outcome is expected from the prescribed treatment and the plan must state how long the treatment will be administered.

Clearly state treatment performed and treatment plan separately. You must document the services you perform to verify the level, type, and extent of services provided to workers. Refer to WAC 296-20-010(7) and WAC 296-20-01002 (Chart notes).

Add **ER** to the SOAP contents to document work status information.

OVERVIEW OF PAYMENT METHODS

HOSPITAL INPATIENT PAYMENT METHODS

The following is an overview of L&I's hospital inpatient payment methods. See the Facility Services section, page **158**, or refer to Chapter 296-23A WAC for more information.

Self-insurers (see WAC 296-23A-0210)

Self-insurers use Percentage of Allowed Charges (POAC) to pay for all hospital inpatient services.

All Patient Diagnosis Related Groups (AP DRG)

L&I uses All Patient Diagnosis Related Groups (AP DRG) to pay for most inpatient hospital services.

Per Diem

L&I uses statewide average per diem rates for 5 AP DRG categories:

- Chemical dependency
- Psychiatric
- Rehabilitation
- Medical
- Surgical

Hospitals paid using the AP DRG method are paid per diem rates for AP DRGs designated as low volume.

Percent of Allowed Charges (POAC)

L&I uses a POAC payment method:

- For some hospitals that are exempt from the AP DRG payment method
- As part of the outlier payment calculation for hospitals paid by the AP DRG

HOSPITAL OUTPATIENT PAYMENT METHODS

The following is an overview of L&I's payment methods for hospital outpatient services. Refer to Chapter 296-23A WAC and the Facility Services section for more information.

Self-insurers

Self-insurers use the maximum fees in the Professional Services Fee Schedule to pay for:

- Radiology,
- Pathology,
- Laboratory,
- Physical therapy and
- Occupational therapy services

Self-insurers use POAC to pay for hospital outpatient services that are not paid with the Professional Services Fee Schedule. See WAC 296-23A-0221 for more information.

Ambulatory Payment Classifications (APC)

L&I pays for most hospital outpatient services with the Ambulatory Payment Classifications (APC) payment method.

Professional Services Fee Schedule

L&I pays for most services not paid with the APC payment method according to the maximum fees in the Professional Services Fee Schedule.

Percent of Allowed Charges (POAC)

Hospital outpatient services are paid by a POAC payment method when they are **not paid**

- With the APC payment method,
- The Professional Services Fee Schedule or
- By L&I contract.

AMBULATORY SURGERY CENTER PAYMENT METHODS

Ambulatory Surgery Center (ASC) Rate Calculations

Insurers use a modified version of the ASC payment system that was developed by the Centers for Medicare and Medicaid Services (CMS) to pay for facility services in an ASC. Refer to Chapter 296-23B WAC in the Medical Aid Rules and the Facility Services section for more information.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for by report services may be based on the value of the service as determined by the report.

Max Fees

L&I establishes rates for some services that are not priced with other payment methods.

PAIN MANAGEMENT PAYMENT METHODS

Chronic Pain Management Program Fee Schedule

The insurer pays for Chronic Pain Management Program Services using an all inclusive, phase-based, per diem fee schedule.

RESIDENTIAL FACILITY PAYMENT METHODS

Self-insurers

Self-insurers use negotiated rates to pay for all residential facility services.

Boarding Homes and Adult Family Homes

L&I uses per diem fees to pay for medical services provided in Boarding Homes and Adult Family Homes.

Nursing Homes and Transitional Care Units

L&I uses modified Resource Utilization Groups (RUGs) to develop daily per diem rates to pay for Nursing Home Services.

PROFESSIONAL PROVIDER PAYMENT METHODS

Resource Based Relative Value Scale (RBRVS)

The insurers use the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. More information about RBRVS is contained in the Professional Services section. Services priced according to the RBRVS fee schedule have a fee schedule indicator of **R** in the Professional Services Fee Schedule.

Anesthesia Fee Schedule

Insurers pay for most anesthesia services using anesthesia base and time units. More information is available in the Professional Services section.

Pharmacy Fee Schedule

Insurers pay pharmacies for drugs and medications according to the pharmacy fee schedule. More information is available in the Professional Services section.

Average Wholesale Price (AWP)

L&I's rates for covered drugs dispensed from a prescriber's office are priced based on a percentage of the AWP of the drug. Drugs priced with an AWP method have AWP in the Dollar Value columns and a **D** in the fee schedule indicator column of the Professional Services Fee Schedule.

Clinical Laboratory Fee Schedule

L&I's clinical laboratory rates are based on a percentage of the clinical laboratory rates established by CMS. Services priced according to L&I's clinical laboratory fee schedule have a fee schedule indicator of **L** in the Professional Services Fee Schedule.

Flat Fees

L&I establishes rates for some services that are priced with other payment methods. Services priced with flat fees have a fee schedule indicator of **F** in the Professional Services Fee Schedule.

L&I Contracts

L&I pays for some services by contract. Some of the services paid by contract include:

- Transcutaneous electrical nerve stimulator (TENS) units and supplies,
- Utilization management and
- Chemically related illness center services.

Services paid by contract have a fee schedule indicator of **C** in the Professional Services Fee Schedule.

The Crime Victims Compensation Program does not contract for these services.

By Report

Insurers pay for some covered services on a by report basis as defined in

WAC 296-20-01002. Fees for by report (BR) services may be based on the value of the service as determined by the report. Services paid by report have a fee schedule indicator of **N** in the Professional Services Fee Schedule and BR in other fee schedules.

BILLING CODES AND MODIFIERS

L&I's fee schedules use the federal HCPCS and agency unique local codes.

> **NOTE:** There are no descriptions for CPT® codes and only partial descriptions of HCPCS or CDT codes in the fee schedule. Providers must bill according to the full text descriptions published in the CPT® and HCPCS books. These can be purchased from private sources. Refer to WAC 296-20-010(1) for additional information.

HCPCS Level I codes are the CPT® codes that are developed, updated and copyrighted annually by the American Medical Association (AMA.) There are 3 categories of CPT® codes:

- **CPT® Category I** codes are used for professional services and pathology and laboratory tests. These are clinically recognized and generally accepted services, not newly emerging technologies. They consist of 5 numbers (for example, 99201).
- **CPT® Category II** codes are optional and used to facilitate data collection for tracking performance measurement. They consist of 4 numbers followed by an **F** (for example, 0001F).
- **CPT® Category III** codes are temporary and used to identify new and emerging technologies. They consist of 4 numbers followed by a **T** (for example, 0001T).

HCPCS Level I modifiers are the CPT® modifiers that are developed, updated and copyrighted by the AMA. These are used to indicate that a procedure or service has been altered without changing its definition. They consist of 2 numbers (for example, –22). **L&I does not accept the 5 digit modifiers.**

HCPCS Level II codes, commonly called HCPCS (pronounced Hick-Picks), are updated by the Center for Medicare & Medicaid Services (CMS).

HCPCS codes are used to identify:

- Miscellaneous services
- Supplies
- Materials
- Drugs
- Professional services

These codes begin with 1 letter, followed by 4 numbers (for example, K0007).

Codes beginning with **D** are developed and copyrighted by the American Dental Association (ADA) and are published in the *Current Dental Terminology* (CDT-3).

HCPCS Level II modifiers are updated by CMS and are used to indicate that a procedure has been altered. They consist of 2 letters (for example, –AA) or 1 letter and 1 number (for example, –E1).

Local codes are used to identify L&I unique services or supplies. They consist of 4 numbers followed by 1 letter (except F and T). For example, 1040M must be used to code completion of L&I's Report of Accident form. L&I will modify local code use as national codes become available.

Local modifiers are used to identify L&I modifications to services. They consist of 1 number and 1 letter (for example, –1S). L&I will modify local modifier use as national modifiers become available.

REFERENCE GUIDE FOR CODES AND MODIFIERS

	HCPCS Level I			HCPCS Level II	
	CPT® Category I	**CPT® Category II**	**CPT® Category III**	**HCPCS**	**L&I Unique Local Codes**
Source	AMA / CMS	AMA / CMS	AMA / CMS	AMA / CMS	L&I
Code Format	5 numbers	4 numbers followed by F	4 numbers followed by T	1 letter followed by 4 numbers	4 numbers followed by 1 letter (not F or T)
Modifier Format	2 numbers	N/A	N/A	2 letters or 1 letter followed by 1 number	1 number followed by 1 letter
Purpose	Professional services, pathology and laboratory tests	Tracking codes to facilitate data collection for tracking performance measurement	Temporary codes for new and emerging technologies	Miscellaneous services, supplies, materials, drugs and professional services	L&I unique services, materials and supplies

CURRENT PROVIDER BULLETINS

Provider Bulletins are temporary communications that give official notification of new or revised rules, laws, coverage decisions, policies, and/or programs that have not been previously published.

Current Provider Bulletins are available on L&I's web site at http://www.LNI.wa.gov/ClaimsIns/Providers/Billing/ProvBulletins/default.asp.

NOTE: If a Provider Bulletin is not listed on L&I's web site, it is no longer current.

CURRENT COVERAGE DECISIONS FOR MEDICAL TECHNOLOGIES & PROCEDURES

The following coverage decisions were made by the Office of the Medical Director. See L&I's web site at http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/default.asp for more information.

Coverage Decisions for Medical Technologies & Procedures
This information is current as of March 10, 2008.

Covered by workers compensation?				
Topic	Yes			No
	With proper documentation	Only with pre-authorization	On a case-by-case basis	
Acupuncture				X
AquaMED (or dry hydrotherapy)	X			
Artificial disc replacement				X
Autologous blood injections				X
Autologous chondrocyte implantation (ACI)		X		
Bloodborne pathogens	x			
Bone cements for use during kyphoplasty and vertebroplasty				X
Bone growth stimulators		X		
Bone morphogenic proteins (BMP) for long bone nonunions and spinal fusions		X		
Botulinum toxin		X		
Brevio® Nerve Conduction Testing System				X
Cervical traction devices	X			
Ctrac[tm] for CTS wrist splint				X
Dry needling		X		
Duragesic			X	
Electrical Stimulation for Chronic Wounds		X		
Electrodiagnositc Sensory Nerve Conduction Threshold (sNCT)				X
Epidural adhesiolysis		X		
ERMI Flexionator and Extensionater				X
Extracoporeal Shockwave Therapy (ESWT)				X
Fibromyalgia				X
Futures Unlimited	X			
Hyaluronic acid	X			
IDET (Intradiscal heating)				X
Interferential therapy units	X (clinical use)	X (home use)		
Low level laser therapy				X
MedX lumbar extension machine	X			
Meniscal allograft transplantation		X		
Microprocessor-controlled prosthetic knees				X
NC-stat® Nerve Conduction System-NeuroMetrix®				X
Neuromuscular electrical stimulators (NMES)	X(clinical use)	X (home use)		
Otto Bock Vacuum Assisted Socket System				X
Percutaneous Discectomy for Disc Herniation				X
Percutaneous Neuromodulation Therapy for low back pain				X
Posterior Lumbar Interbody Fusion (PLIF)		X		
Powered Traction Devices for Intervertebral Decompression	X			
Smoking cessation		X		
Standing, Weight-bearing, Positional & Upright[tm] MRI				X
Thermal shrinkage for instability				X
Tinnitus Retraining Therapy				X
UniSpacer				X
Wound VAC			X	
X-STOP® interspinous process device				X

Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the Medical Aid Rules and Fee Schedules (MARFS) and Provider Bulletins. If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

COVERED SERVICES

L&I makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a **covered** benefit.

Procedure codes listed as **not covered** in the fee schedules are **not covered** for the following reasons:

1. The treatment is not safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The insurer may pay for procedures in the first 2 categories above on a case-by-case basis. The health care provider must:

- Submit a written request and
- Obtain approval from the insurer prior to performing any procedure in these categories.

The request must contain:

- The reason,
- The potential risks and expected benefits,
- The relationship to the accepted condition and
- Any additional information about the procedure that may be requested by the insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to 1 unit per day. For example, only 1 unit is payable for CPT® code 97022 regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

PHYSICIAN ASSISTANTS

Physician assistants (PAs) must be certified and have valid individual L&I provider account numbers to be paid for services. PAs should use billing modifiers outlined in the RBRVS Payment Policies Section of MARFS. For example, to bill for Assistant at Surgery, the PA would use modifier –80, –81 or –82 as appropriate.

Physician assistants may sign any documentation required by the department but consultations and impairment ratings services related to workers' compensation benefit determinations are not payable to physician assistants as specified in RCW 51.28.100 and WAC 296-20-01501.

Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee. For more information about physician assistant services and payment, see WAC 296-20-12501, WAC 296-20-01501 and WAC 296-20-01502.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

L&I uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. These services have a fee schedule indicator (FSI) of **R** in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on:

- Relative value units (RVUs),
- Geographic adjustment factors for Washington State and
- A conversion factor.

The maximum fee for a procedure is obtained by multiplying the adjusted RVU by the conversion factor. L&I's maximum fees are published as dollar values in the Professional Services Fee Schedule.

Under the Centers for Medicare and Medicaid Services (CMS) approach, RVUs are assigned to each procedure based on the resources required to perform the procedure, comprised of:

- The work,
- Practice expense and
- Liability insurance (malpractice expense).

A procedure with an RVU of 2 requires half the resources of a procedure with an RVU of 4.

Geographic adjustment factors are used to correct for differences in the cost of operating in different states and metropolitan areas producing an adjusted RVU described below.

The conversion factor is published in WAC 296-20-135. It has the same value for all services priced according to the RBRVS. L&I may annually adjust the conversion factor by a process defined in WAC 296-20-132.

Three state agencies, Labor and Industries (L&I), Health Care Authority (HCA) and Department of Social and Health Services (DSHS), use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2008 Medicare Physician Fee Schedule Database (MPFSDB), which was published by CMS in the November 27, 2007 *Federal Register*. The *Federal Register* can be accessed online at http://www.gpoaccess.gov/fr/index.html or can be purchased from the U.S. government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents or http://bookstore.gpo.gov/
PO Box 371954
Pittsburgh, PA 15250-7954

The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2008 are:

- 99.5% of the work component RVU,
- 101.6% of the practice expense RVU and
- 75.1% of the malpractice RVU.

To calculate the insurer's maximum fee for each procedure:

1. Multiply each RVU component by its geographic adjustment factor,
2. Sum the geographically adjusted RVU components, rounding to the nearest hundredth,
3. Multiply the rounded sum by L&I's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy. The insurer will pay professional services at the RBRVS rates for facility and nonfacility settings based on where the service was performed. Therefore, it is important to **include a valid 2-digit place of service code on your bill**.

L&I's maximum fees for facility and nonfacility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the insurer makes 2 payments, one to the professional provider and another to the facility. The payment to the facility includes:

- Resource costs such as labor,
- Medical supplies and
- Medical equipment.

To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the insurer also makes a payment to a facility. The following codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgery center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Billing Tip

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Nonfacility Settings

When services are provided in nonfacility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for nonfacility settings.

Professional services will be paid at the RBRVS rate for nonfacility settings when the insurer does not make a separate payment to a facility. The following place of service codes will be paid at the rate for nonfacility settings:

Place of Service Code	Place of Service Description
01	Pharmacy
03	School
04	Homeless shelter
09	Correctional facility
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
16	Temporary lodging
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Nonresidential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory

Facilities will be paid at the RBRVS rate for nonfacility settings when the insurer does not make a separate payment directly to the provider of the service.

Remember to include a valid 2-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

DOCUMENTATION AND BILLING

The history, examination and decision making are the key components in determining the level of E/M service to bill. Providers must use one of the following guidelines to determine the appropriate level of service.

The *1995 Documentation Guidelines for Evaluation & Management Services* available at *www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf*

or

The *1997 Documentation Guidelines for Evaluation and Management Services* available at *www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf*

Chart notes must contain documentation that justifies the level of service billed.

NEW AND ESTABLISHED PATIENT

L&I uses the CPT® definitions of new and established patients. If a patient presents with a work related condition and meets the definition in a provider's practice as

- A new patient, then a new patient E/M should be billed.
- An established patient, then an established patient E/M service should be billed, even if the provider is treating a new work related condition for the first time.

MEDICAL CARE IN THE HOME OR NURSING HOME

L&I allows attending providers to charge for E/M services in:

- Nursing facilities,
- Domiciliary, boarding home or custodial care settings and
- The home

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M is allowed with a maximum of 3 hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and 1of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99304-99310
99357	99356 and 1of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact are bundled and are not payable in addition to other E/M codes.

A narrative report is required when billing for prolonged evaluation and management services. See Appendix G for additional information.

USING THE –25 MODIFIER

Modifier –25 must be appended to an E/M code when reported with another procedure on the same date of service. The E/M visit and the procedure must be documented separately.

Modifier –25 must be reported in the following circumstances to be paid:

- Same patient, same day encounter at a separate visit; and
- Same physician or provider; and
- Patient condition required a "significant separately identifiable E/M service above and beyond the usual pre and post care" related with the procedure or service.

Example 1:

A worker goes to an osteopathic physician's office to be treated for back pain. The physician:

- Reviews the history,
- Conducts a review of body systems and
- Performs a clinical examination

The physician then advises the worker that osteopathic manipulation is a therapeutic option for treatment for the condition. The physician performs the manipulation during the office visit. This is a significant separately identifiable procedure performed at the time of the E/M service.

For this office visit, the physician may bill the appropriate:

- CPT® code for the manipulation and
- E/M code with the –25 modifier

Example 2:

A worker goes to a physician's office for a scheduled follow up visit for a work related injury. During the examination, the physician determines that the worker's condition requires a course of treatment that includes a trigger point injection at this time. The trigger point injection was not scheduled previously as part of the E/M visit.

The physician gives the injection during the visit. This is a significant separately identifiable procedure performed at the time of the E/M service. For the same time and date of service, the physician may bill the appropriate:

- CPT® code for the injection and
- E/M code with the –25 modifier

Example 3:

A worker arrives at a physician's office in the morning for a scheduled follow up visit for a work related injury. That afternoon, the worker's condition worsens and the worker seeks immediate medical attention and returns to the office without an appointment. The office staff or triage nurse agrees that the worker needs to be seen.

The provider sees the patient for a second office visit. Since the 2 visits were completely separate, both E/M services may be billed. The scheduled visit would be billed with the:

- E/M code alone and
- Unscheduled visit would be billed with the E/M code with the –25 modifier.

TREATING 2 SEPARATE CONDITIONS/SPLIT BILLING POLICY

If the worker is treated for 2 separate conditions at the same visit, the charge for the service must be divided equally between the payers. If evaluation and treatment of the 2 injuries increases the complexity of the visit, a higher level E/M code might be billed. If this is the case, CPT® guidelines must be followed and the documentation must support the level of service billed. A physician would only be paid for more than 1 evaluation and management visit if there were 2 separate and distinct visits on the same day (see the Example 3 above). **Scheduling back-to-back appointments does not meet the criteria for using the –25 modifier.**

Separate chart notes and reports must be submitted when there are 2 different claims. The claims may be from injuries while working for 2 different employers and the employers only have the right to information about injuries they are responsible for.

List all workers' compensation claims treated in Box 11 of the CMS-1500 form when submitting paper bills to L&I and in the remarks section when submitting electronic claims. L&I will divide charges equally to the claims.

If part of the visit is for a condition unrelated to an accepted L&I or self-insured claim and part is for the accepted condition, providers must apportion their usual and customary charges equally between L&I or the self-insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer does not have the right to see information about an unrelated condition.

Example 1:

A worker goes to a physician to be treated for a work related shoulder injury and a separate work related knee injury. The physician treats both work related injuries. The provider bills L&I for 1 visit listing both workers' compensation claims in Box 11 of the CMS-1500 form. L&I will divide charges equally to the claims.

Example 2:

A worker goes to a physician's office to be treated for work related injury (L&I or self-insured claim). During the examination, the worker mentions that he was in a car accident yesterday and now has neck pain. The physician treats the work related injury and the neck pain associated with the motor vehicle accident. The provider would bill 50% of his usual and customary fee to L&I or self-insurer and 50% to the insurance company paying for the motor vehicle accident. L&I or self-insurer would only be responsible for the portion related to the accepted work related injury.

PHYSICIAN STANDBY SERVICES

The insurer pays for physician standby services when all the following criteria are met:

- Another physician requested the standby service; and
- The standby service involves prolonged physician attendance without direct face-to-face patient contact; and
- The standby physician is not concurrently providing care or service to other patients during this period; and
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30 minute period downward. A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team Conferences

Team conferences may be payable when the attending provider, consultant or psychologist meets with one or more of the following:

- An interdisciplinary team of health professionals
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- L&I medical consultants
- Self-insurer representatives or employers
- Physical and occupational therapists and speech-language pathologists

Billing codes

Patient status	CPT® code (Physicians)	CPT® code (Nonphysicians)
Patient present	Appropriate level E&M	99366
Patient not present	99367	99368

Multiple units of 99366, 99367 and 99368 may be billed for conferences exceeding 30 minutes:

Duration of conference	Units billed
Up to 30 minutes	1 unit
Up to 60 minutes	2 units

Physical and Occupational Therapists

Physical and occupational therapists and speech-language pathologists may be paid for attendance at a team conference only when the conference is authorized in advance by the Medical Director/Associate Medical Director at L&I or the self-insured employer.

To be authorized all of the following criteria must be met:

- There is a moderate to high probability of severe, prolonged functional impairment. This may be addressed with the development of a multidisciplinary approach to the plan of care; and
- The need for a conference exceeds the expected routine correspondence/communication among healthcare/vocational providers; and
- The worker is not participating in a program in which payment for conference is already included in the program payment (For example, head injury program, pain clinic, work hardening); and
- 3 or more disciplines/specialties need to participate, including PT, OT or Speech.

To be paid for the conference the therapists must:

- Bill using CPT® code 99366 if the patient is present or 99368 if the patient is not present.
- Bill on a CMS-1500 form
- Submit a separate report of the conference; joint reports are not allowed. The conference report must include:
  - Evaluation of the effectiveness of the previous therapy plan; and
  - New goal-oriented, time-limited treatment plan or
  - Objective measures of function that address the return to work process.
  - Duration of the conference

NOTE: Providers in a hospital setting may only be paid if the services are billed on a CMS-1500 with an individual provider account number.

Telephone Calls

Telephone calls are payable to the attending provider, consultant, psychologist or other provider only when they personally participate in the call. These services are payable when discussing or coordinating care or treatment with:

- The worker
- L&I staff
- Vocational rehabilitation counselors
- Nurse case managers
- L&I medical consultants
- Other physician consultants
- Self-insurer representatives or employers

NOTE: L&I does not adhere to the CPT® limits for telephone calls

Telephone calls **are payable** regardless of when the previous or next office visit occurs.

ARNPs, PAs, PTs and OTs must bill using nonphysician codes.

Telephone calls **are not payable** for authorization, resolution of billing issues or ordering prescriptions.

Duration	CPT® code (Physicians)	CPT® code (Nonphysicians)
5-10 minutes	99441	98966
11-20 minutes	99442	98967
21-30 minutes	99443	98968

Documentation Requirements

Documentation for case management services (team conferences and telephone calls) must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for these services when also providing consultation or evaluation.

Team conference documentation must also include a goal-oriented, time-limited treatment plan covering:

- Medical,
- Surgical,
- Vocational or return to work activities, or
- Objective measures of function

The plan must allow a determination whether a previously created plan is effective in returning the worker to an appropriate level of function.

Online Communications and Consultations

Electronic online communications (e-mail) with the worker are payable only when personally made by the attending provider, consultant, psychologist or physical or occupational therapist who has an existing relationship with the worker.

Online communications must be conducted over a secure network, developed and implemented using guidelines from reputable industry sources such as those published by:

- The American Medical Association
- The Federation of State Medical Boards
- The eRisk Working Group for Healthcare

Services payable for communications with workers include:

- Follow up care resulting from a face-to-face visit that does not require a return to the office.
- Non-urgent consultations regarding an accepted condition when the equivalent service provided in person would have resulted in a charge.
- Reporting and interpreting diagnostic tests that require counseling and adjustments to treatment or medications.
- Discussions of return-to-work activities with workers and employers.

Services not payable include:

- Routine requests for appointments.
- Test results that are informational only.
- Requests for prescription refills.
- Consultations that result in an office visit.

Electronic communications are also payable when discussing or coordinating care, treatment or return-to-work activities with:

- L&I staff
- Vocational rehabilitation counselors
- Case managers
- L&I medical consultants
- Self-insured representatives
- Employers

Documentation Requirements

Documentation for electronic communications must include:

- The date, and
- The participants and their titles, and
- The nature of the communication, and
- All medical, vocational or return to work decisions made.

Provider and CPT® code	Nonfacility fee	Facility fee
Physician - 99444	$40.61	$38.76
Nonphysician - 98969	$40.61	$38.76

PHYSICIAN CARE PLAN OVERSIGHT

The insurer allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to 1 per attending provider, per patient, per 30 day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30 day period are considered part of E/M services and **are not** separately payable.

Payment for care plan oversight to a physician providing post surgical care during the postoperative period will be made only:

- If the care plan oversight is documented as unrelated to the surgery and
- Modifier –24 is used.

The attending provider (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS

L&I adopted a modified version of CMS's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient and consultant.

Coverage of Teleconsultations

Teleconsultations **are covered** in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002 or a PhD Clinical Psychologist. A consulting DC must be an approved consultant with L&I; and
- The **referring provider** must be 1 of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The exam of the patient must be under the control of the consultant; and
- Interactive audio and video telecommunications must be used allowing real time communication between the patient and the consultant; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Consultants

Teleconsultations are paid in the same manner as face-to-face consultations. The insurers will pay according to the following criteria:

- Consultants must append a **GT** modifier to 1 of the appropriate services listed in the table below.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the insurer.

The Consultant may bill these services:
Consultation codes
Office or other outpatient visits
Psychiatric intake and assessment
Individual psychotherapy
Pharmacologic management
End stage renal disease (ESRD) services

Originating Facility

The insurer will pay an originating site facility fee for the use of the telecommunications equipment. Bill for these services with HCPCS code:

Q3014 ..... $34.19

The insurer will only pay for a professional service by the referring provider if it is a separately identifiable service provided on the same day as the telehealth service.

Documentation for both must be clearly and separately identified in the medical record.

Telemedicine Services Not Covered

Procedures and services **not covered** include:

- "Store and Forward" technology, asynchronous transmission of medical information to be reviewed by the consultant at a later time.
- Facsimile transmissions.
- Installation or maintenance of telecommunication equipment or systems.
- Home health monitoring.
- Telehealth transmission, per minute (HCPCS code T1014).

END STAGE RENAL DISEASE (ESRD)

L&I follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99307-99310) **are not payable** on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment will be allowed when billed on the same date as an inpatient dialysis service for:

- An initial hospital visit (CPT® codes 99221-99223),
- An initial inpatient consultation (CPT® codes 99251-99255) and
- A hospital discharge service (CPT® code 99238 or 99239)

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the Fol-Up column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- The following services:
  - Dressing changes;
  - Local incisional care and removal of operative packs;
  - Removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints;
  - Insertion, irrigation and removal of urinary catheters routine peripheral IV lines, nasogastric and rectal tubes;
  - Change and removal of tracheostomy tubes; and
  - Cast room charges.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

NOTE: Casting materials **are not** part of the global surgery policy and are paid separately.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performed any component of the surgery (The pre, intra, and/or postoperative care of the patient; identified by modifiers –56, –54 and –55)
- Assistant surgeon (identified by modifiers –80, –81 and –82)
- 2 surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier –22, –24, –25, –57, –58, –78 or –79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99315-99318	92012-92014
99218-99220	99334-99337	
99231-99239	99347-99350	
99291-99292	99304-99310	

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (for example, they are not payable for scheduled hospital admissions).

Codes that are considered bundled are **not payable** during the global surgery follow-up period.

Services and Supplies Not Included in the Global Surgery Policy

- The initial consultation or evaluation by the surgeon to determine the need for surgery.
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care.
- Visits unrelated to the diagnosis of the surgical procedure performed, unless the visits occur due to surgery complications.
- Treatment for the underlying condition or an added course of treatment which is not part of the normal surgical recovery.
- Diagnostic tests and procedures, including diagnostic radiological procedures.
- Distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
- Treatment for postoperative complications which requires a return trip to the operating room (OR).
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately.
- Immunotherapy management for organ transplants.
- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

PRE, INTRA OR POSTOPERATIVE SERVICES

The insurer will allow separate payment when different providers perform the preoperative, intraoperative or postoperative components of the surgery. The modifiers (–54, –55 or –56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both physicians.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the insurer only allows payment for an E/M office visit during the global period when:

- A documented, unrelated service is furnished during the postoperative period and modifier –24 is used, or
- The provider who performs the procedure is seeing the patient for the first time an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

Modifier –57, decision for surgery, is not payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.

50% of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

More than 5 procedures require documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the patient on the same day, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures.
- Other modifier policies.
- Standard multiple surgery policy.

When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as 2 line items. Modifier –50 must be applied to the second line item. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum. Bilateral procedures are considered 1 procedure when determining the highest valued procedure before applying multiple surgery rules.

Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (nonfacility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	$ 644.83		$ 644.83 (1)
2	64721-50	$ 644.83	$ 322.42 (2)	$ 322.42
			Total Allowed Amount in Nonfacility Setting:	$ 967.25 (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) Represents total allowable amount.

Example: Bilateral Procedure and Multiple Procedures

Line Item	CPT® Code/Mod	Max Payment (nonfac setting)	Bilateral Applied	Multiple Applied	Allowed Amount
1	63042	$ 2021.88			$ 2021.88 (1)
2	63042-50	$ 2021.88	$ 1010.94 (2)		$ 1010.94
					subtotal $ 3032.82 (3)
3	22612-51	$ 2472.89		$ 1236.45 (4)	$ 1236.45
Total Allowed Amount in Nonfacility Setting:					$ 4269.27 (5)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the 2 line items will be treated as 1 procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) The combined bilateral allowed amount is used to determine the highest valued procedure when applying the multiple surgery rule.
(4) The third line item billed with modifier –51 is paid at 50% of the maximum payment.
(5) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, endoscopy will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment is not allowed for an E/M office visit on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related families. Each endoscopy family contains a base procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the Endo Base column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, Endoscopy Families.

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. The endoscopy procedure with the highest dollar value is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, payment is the difference between the family member and the base fee.
3. When the fee for the family member is less than the base fee, the payment is $0.00 (see Example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an endoscopic group. If more than 1 endoscopic group or other nonendoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see Examples 3 and 4).

Multiple endoscopies that are not related (Each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: 2 Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	29870	$ 635.60	$ 000.00 (2)	
1	29874	$ 834.96	$ 199.36 (4)	$ 199.36 (5)
2	29880	$ 1068.78	$ 1068.78 (3)	$ 1068.78 (5)
			Total Allowed Amount in Nonfacility Setting:	$ 1268.14 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Payment is not allowed for a base code when a family member is billed.
(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(5) Amount allowed under the endoscopy policy.
(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only 1 family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member with Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	$ 481.78		
1	43241	$ 246.12	$ 000.00 (2)	
2	43251	$ 345.80	$ 345.80 (3)	$ 345.80 (4)
			Total Allowed Amount in Nonfacility Setting:	$ 345.80 (5)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.
(4) Allowed amount under the endoscopy policy.
(5) Represents total allowed amount. Standard multiple surgery policy does not apply because only 1 endoscopic group was billed.

Example 3: 2 Surgical Procedures Billed with an Endoscopic Group (highest fee)

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	$ 237.51		$ 118.76 (5)
2	11406	$ 433.79		$ 216.90 (5)
Base (1)	29830	$ 708.21		
3	29835	$ 791.28	$ 83.07 (3)	$ 83.07 (4)
4	29838	$ 928.49	$ 928.49 (2)	$ 928.49 (4)
			Total Allowed Amount in Nonfacility Setting:	$ 1347.22 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

Example 4: 1 Surgical Procedure (highest fee) Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (nonfacility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	29827	$ 1720.38		$ 1720.38 (4)
Base (1)	29805	$ 735.28		
3	29824	$ 1044.78	$ 309.50 (3)	$ 154.75 (5)
4	29826	$ 1054.62	$ 1054.62 (2)	$ 527.31 (5)
			Total Allowed Amount in Nonfacility Setting:	$ 2402.44 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued endoscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued endoscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the nonbase code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or endoscopy group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an add-on surgical code that indicates an operative microscope has been used. As an add-on code, it is not subject to multiple surgery rules.

CPT® code 69990 is not payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (for example the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 may not be billed with CPT® code 31535 because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT®Code	CPT®Code	CPT®Code	CPT®Code
15756-15758	26551-26554	31561	63075-63078
15842	26556	31571	64727
19364	31526	43116	64820-64823
19368	31531	43496	65091-68850
20955-20962	31536	49906	
20969-20973	31541-31546	61548	

SPINAL INJECTION POLICY

Injection procedures are divided into 3 categories; injection procedures that:

1. Require fluoroscopy.
2. May be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they are not performed at a certified or accredited facility.
3. Do not require fluoroscopy.

Definition of Certified or Accredited Facility

L&I defines a certified or accredited facility as a facility or office that has certification or accreditation from 1 of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	CPT® Fluoroscopy Codes(1),(2)
62268	77002, 77012, 76942
62269	77002, 77012, 76942
62281	77003, 72275
62282	77003, 72275
62284	77003, 77012, 76942, 72240, 72255, 72265, 72270
62290	72295
62291	72285
62292	72295
62294	77002, 77003, 77012, 75705
62310	77003, 72275
62311	77003, 72275
62318	77003, 72275
62319	77003, 72275
64470	77003
64472	77003
64475	77003
64476	77003
64479	77003, 72275
64480	77003, 72275
64483	77003, 72275
64484	77003, 72275

(1) One of these fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.

(2) Only 1 of these codes may be billed for each injection.

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. The physician must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code
62310
62311
62318
62319

Spinal Injection Procedures that Do Not Require Fluoroscopy

CPT® Code
62270
62272
62273

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection(3)	–26 Component of Professional Services Fee Schedule
	Radiology	–26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	–TC Component of Professional Services Fee Schedule
Hospital(1)	Injection	APC or POAC
	Radiology(2)	APC or –TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	–TC Component of Professional Services Fee Schedule

(1) Payment method depends on a hospital's classification.
(2) Radiology codes may be packaged with the injection procedure.
(3) A separate payment for the injection will **not be made** when computed tomography is used for imaging unless documentation demonstrating medical necessity is provided.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may be paid to perform surgical assistant services if they submit the following documents to the insurer.

1. A photocopy of her/his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

NOTE: L&I also requires a completed provider application.

Payment for these services is 90% of the allowed fee that would be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Modifier –SU denotes the use of facility and equipment while performing a procedure in a physician's office.

Modifier –SU is **not covered** and the insurer will not make a separate facility payment. Procedures performed in a physician's office are paid at nonfacility rates that include office expenses.

Physicians' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter 296-23B WAC for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies CPT® code 35400 is limited to only 1 unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The insurer **may cover** autologous chondrocyte implant (ACI) when all of the guidelines outlined in Provider Bulletin 06-07, *Autologous Chondrocyte Implantation*, are met. ACI requires **prior authorization**.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have received training through Genzyme Biosurgery and
- Have performed or assisted with 5 ACI procedures or
- Perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

The appropriate CPT® code for the implant is 27412. Use CPT® code 29870 for harvesting the chondrocytes.

If the procedure is authorized, the insurer will pay US Bioservices for Carticel® (autologous cultured chondrocytes). For more information, go to http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/autoChondImplant.asp

Bone Morphogenic Protein

The insurer **may cover** the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft is not feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at 1 level from L4-S1.

CPT® codes used depend on the specific procedure being performed.

All of the criteria and guidelines must be met before the insurer will authorize the procedures. For more information, go to http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/autoChondImplant.asp In addition, lumbar fusion guidelines must be met. For more information, go to http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/TreatGuide/default.asp

Bone Growth Stimulators

The insurer, with **prior authorization**, pays for bone growth stimulators for specific conditions when proper and necessary, including:

- Noninvasive or external stimulators including those that create a small electrical current and those that deliver a low intensity ultrasonic wave to the fracture, and
- Implanted electrical stimulators that supply a direct current to the bone.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/boneGrowth.asp

Billing Codes for Bone Growth Stimulators

Billing Code	Description	Prior Auth.
E0747	Osteogenesis stimulator, electrical, noninvasive, other than spinal application	Required
E0748	Osteogenesis stimulator, electrical, noninvasive, spinal application	Required
E0749	Osteogenesis stimulator, electrical (surgically implanted)	Required
E0760	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Required

Botulinum Toxin

The insurer covers botulinum toxin injections (Botox®: BTX-A, Myobloc®: BTX-B) **with prior authorization** for the following indications when it is proper and necessary:

- Blepharospasm
- Primary axillary hyperhidrosis
- Cervical dystonia (spasmodic torticollis)
- Strabismus
- Hemifacial spasm
- Torsion dystonia (idiopathic/symptomatic)
- Laryngeal or spasmodic dysphonia
- Torticollis, unspecified
- Orofacial dyskinesia
- Writer's cramp
- Oromandibular dystonia

Patients must have failed conservative treatment such as other medications and physical therapy before Botox will be authorized.

Noncovered Indications

The insurer will not authorize payment for BTX injections for other off-label indications.

Criteria for Additional Injections

The insurer may authorize 1 subsequent injection session administered 90 days after the initial session if the first BTX session produced an adequate, functional response. Physicians must submit documents describing the patient's response to BTX following a session of injections. No more than 2 injections per individual will be authorized due to risk of antibody development and decrease in response.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/botox.asp

Closure of Enterostomy

Closures of enterostomy **are not payable** with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy. CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Epidural Adhesiolysis

The insurer, with **prior authorization**, pays for epidural adhesiolysis using the 1 day protocol but does not pay for the 3 day protocol. Epidural adhesiolysis is also known as percutaneous lysis of epidural adhesions, epidural decompressive neuroplasty, and Racz neurolysis. Workers must meet the following criteria:

- The worker has experienced acute low back pain or acute exacerbation of chronic low back pain of no more than 6 months duration.
- The physician intends to conduct the adhesiolysis in order to administer drugs closer to a nerve.
- The physician documents strong suspicion of adhesions blocking access to the nerve.
- Adhesions blocking access to the nerve have been identified by Gallium MRI or Fluoroscopy during epidural steroid injections.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/epiduralAdhes.asp

Meniscal Allograft Transplantation

The insurer, with **prior authorization**, may cover meniscal allograft transplantation when all of the guidelines are met.

In addition to the clinical guidelines for the procedure, the surgeon must:

- Have performed or assisted with 5 meniscal allograft transplants or
- Perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants.

For more information, go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/Meniscal.asp

ANESTHESIA SERVICES

Anesthesia payment policies are established by L&I with input from the Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NONCOVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The insurer does not cover anesthesia assistant services.

Noncovered Procedures

Anesthesia is not payable for procedures that are **not covered** by L&I. Refer to **Appendix D** for a list of noncovered procedures.

Patient Acuity

Patient acuity does not affect payment levels. Payment for CPT® codes 99100, 99116, 99135 and 99140 is considered bundled and is not payable separately. CPT® physical status modifiers (–P1 to –P6) and CPT® 5-digit modifiers are not accepted.

Payment for Anesthesia

Payment for anesthesia services will only be made to anesthesiologists and certified registered nurse anesthetists.

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier –47 (anesthesia by surgeon) are considered bundled and are not payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

CRNA services are paid at a maximum of 90% of the allowed fee that would be paid to a physician.

Refer to WAC 296-23-240 for licensed nursing rules and 296-23-245 for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to L&I's CMS-1500 billing instructions (publication F248-094-000).

CRNA services should not be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

L&I follows CMS's policy for medical direction of anesthesia (team care).

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a preanesthetic examination and evaluation, and
- Prescribe the anesthesia plan, and
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, and
- Make sure any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual as defined in program operating instructions, and
- Monitor the course of anesthesia administration at frequent intervals, and
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated postanesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, and
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation Requirements for Team Care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not submit documentation with the bill, but must make it available to the insurer upon request.

Billing for Team Care

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate CMS-1500 forms using their own provider account numbers.
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (–QK or –QY).
- CRNAs should use modifier –QX.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
  (Refer to Anesthesia Payment Calculation in the Anesthesia Services Paid with Base and Time Units section, page **55**)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

Anesthesia Base Units

Most of L&I's anesthesia base units are the same as the units adopted by CMS. L&I differs from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.

List only the time in minutes on your bill. Do not include the base units. They are automatically added by L&I's payment system.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. Except for modifier –99, these modifiers are not valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® 5-digit modifiers and physical status modifiers (P1 through P6) **are not** paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	–99	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
Anesthesiologists	–AA	Anesthesia services performed personally by anesthesiologist	
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	–QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	–QZ	CRNA service: without medical direction by a physician(1)	Maximum payment is 90% of the maximum allowed for physician services.

(1) Bills from CRNAs that do not contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the

- Base value for the procedure,
- Time the anesthesia service is administered and
- L&I's anesthesia conversion factor.

The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2008, the anesthesia conversion factor is $47.85 per 15 minutes ($3.19 per minute). Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by $3.19.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

Example: CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x $3.19 = $334.95

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 anesthesia add-on CPT® codes: 01953, 01968 and 01969.

- Add-on code 01953 should be billed with primary code 01952.
- Add-on codes 01968 and 01969 should be billed with primary code 01967.
- Add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units.

Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the CMS-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 4 percent	01951	None
5 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services include:

- Anesthesia evaluation and management services,
- Most pain management services and
- Other selected services.

These services paid by the RBRVS payment method and are listed in **Appendix F**.

Modifiers

Anesthesia modifiers –AA, –QK, –QX, –QY and –QZ are not valid for services paid by the RBRVS method.

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

When billing for services paid with the RBRVS method, enter the total **number of times the procedure is performed** in the Units column (Field 24G on the CMS-1500 bill form).

E/M Services Payable with Pain Management Procedures

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the provider who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service. (see Using the -25 modifier)

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to Medication Administration in the Other Medicine Services section; page **81** for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Maximum of 6** injections per acute episode are allowed.
Facet injections	**Maximum of 4** injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other nonscheduled medications and trigger point dry needling(1)	**Maximum of 6** injections per patient are allowed.

(1) Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. L&I does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

RADIOLOGY

X-RAY SERVICES

Repeat X-rays

The insurer **will not pay** for excessive or unnecessary X-rays. Repeat or serial X-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s). Documented changes in objective findings or subjective complaints must support the need.

Number of Views

There is no specific code for additional views for radiology services. Therefore, the number of X-ray views that may be paid is determined by the CPT® description for that service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT® Code	Payable
72020	Once for a single view
72040	Once for 2 to 3 cervical views
72050	Once for 4 or more cervical views
72052	Once, regardless of the number of cervical views it takes to complete the series

Incomplete Full Spine Studies

A full spine study is a radiologic exam of the entire spine; anteroposterior (AP) and lateral views. Depending on the size of the film and the size of the patient, the study may require up to 6 films (the AP and lateral views of the cervical, thoracic and lumbar spine). An incomplete full spine study is one in which the entire AP or lateral view is taken, but not both. For example, a study is performed in which all AP and lateral views are obtained except for the lateral thoracic. Incomplete full spine studies in which 5 views are obtained are payable at the maximum fee schedule amount for CPT® code 72010. Incomplete full spine studies in which 4 views are taken are payable at one-half the maximum fee schedule amount for CPT® code 72010 and must be billed with a –52 modifier to indicate reduced services.

–RT and –LT Modifiers

HCPCS modifiers –RT (right side) and –LT (left side) do not affect payment They may be used with CPT® radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving
  - Extremities,
  - Pelvis,
  - Vertebral column or
  - Skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable X-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s). R0075 will pay based on the number of patients served and the modifier billed. Payment is outlined in the following table.

HCPCS Code	Modifier	Patients Served	Description	Fee
R0070		1	Transport portable X-ray	$164.84
R0075	–UN	2	Transport portable X-ray	$ 82.43
R0075	–UP	3	Transport portable X-ray	$ 54.95
R0075	–UQ	4	Transport portable X-ray	$ 41.21
R0075	–UR	5	Transport portable X-ray	$ 32.97
R0075	–US	6 or more	Transport portable X-ray	$ 27.48

Custody

X-rays must be retained for 10 years. See WACs 296-20-121 and 296-23-140(1).

RADIOLOGY CONSULTATION SERVICES

CPT® code 76140 is **not covered**. For radiology codes where a consultation service is performed, providers must bill the specific X-ray code with the modifier –26. The insurer **will not pay separately** for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the X-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed. Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the consultation is required.

CONTRAST MATERIAL

Separate payment will be made for contrast material for imaging studies. Providers may use either high osmolar contrast material (HOCM) or low osmolar contrast material (LOCM). The use of either type of contrast material must be based on medical necessity.

The brand name of the contrast material and the dosage must be documented in the patient's chart. Use the following codes to bill for contrast material:

- LOCM: Q9951, Q9965 – Q9967
- HOCM: Q9958 - Q9964

HCPCS codes for LOCM are paid at a flat rate based on the AWP per ml. Bill 1 unit per ml. Codes **not** valid for contrast material: A4644, A4645, A4646 and A9525.

NUCLEAR MEDICINE

The standard multiple surgery policy applies to the following radiology codes for nuclear medicine services.

CPT® Code
78306
78320
78802
78803
78806
78807

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient,
  - On the same day,
  - By the same physician or
  - By more than 1 physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

Who May Bill For Physical Medicine Services

Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine services.

- They use CPT® codes 97001 through 97799 and 95831 through 95852 to bill for their services.
- CPT® code 64550 may also be used but is payable only once per claim (see WAC 296-21-290).

Licensed Physical Therapists

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see WAC 296-23-220).

Licensed Occupational Therapists

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Nonboard Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- They **will not be paid** for CPT® codes 97001-97799.
- They may perform physical medicine modalities and procedures described in CPT® codes 97001-97762 if their scopes of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to 6 visits per claim, except when the attending doctor practices in a remote location where no licensed physical therapist is available.
- After 6 visits, the patient must be referred to a licensed, physical or occupational therapist or physiatrist for such treatment except when the attending doctor practices in a remote location. Refer to WAC 296-21-290 for more information.

1044M Physical medicine modality (ies) and/or procedure(s) by attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to 6 visits except when doctor practices in a remote area. ..... $ 43.06

PHYSICAL AND OCCUPATIONAL THERAPY

Billing Codes

Physical and occupational therapists must use the appropriate physical medicine CPT® codes 97001-97799, with the exceptions noted later in the Noncovered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section, page **116**. If more than 1 patient is treated at the same time use CPT® code 97150. Refer to the Physical Medicine CPT® Codes Billing Guidance section, page **63** for additional information.

Noncovered and Bundled Codes

The following physical medicine codes are not covered:

CPT® Code
97005
97006
97033

The following are examples of bundled items or services:

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Theratаping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of noncovered and bundled codes.

Units of Service

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to 1 unit per day:

CPT® Code	CPT® Code
97001	97018
97002	97022
97003	97024
97004	97026
97012	97028
97014	97150
97016	

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see WAC 296-23-220 and WAC 296-23-230..... $ 118.07

The daily maximum applies to CPT® codes 64550, 95831-95852 and 97001-97799 and HCPCS code G0283 when performed for the same claim for the same date of service. If physical and occupational therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition, therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer does not have the right to see information about an unrelated condition.

The daily maximum allowable fee does not apply to:

- Performance based physical capacities examinations (PCEs),
- Work hardening services,
- Work evaluations or
- Job modification/prejob accommodation consultation services.

PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

1045M Performance-based physical capacities evaluation with report and summary of capacities ..... $ 705.78
(Limit of 1 per 30 days)

POWERED TRACTION THERAPY

Powered traction devices **are covered** as a physical medicine modality.

The insurer **will not pay** any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. For more information go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/PTD.asp

WOUND CARE

Debridement

Therapists **cannot bill** the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the Supplies, Materials and Bundled Services section, page **116** for more information.

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is **covered** for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior authorization is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound has not improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds. For more information go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/ElecStimulation.asp

MASSAGE THERAPY

Massage is a **covered** physical medicine service when performed by a licensed massage therapist (WAC 296-23-250) or other provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **will not pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services and the daily maximum allowable amount is ..... $ 88.55

The following are bundled into the massage therapy service and are not separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Refer to WAC 296-23-250 for additional information.

Bill 1 unit of CPT® code 97124 for each 15 minutes of massage therapy. Document the treatment duration to support the units of service billed.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

The following provides guidance regarding the use of CPT® codes 97032-97036, 97110-97124, 97140, 97530-97542 and 97750-97762.

Timed Codes

Several CPT® codes used for therapy modalities, procedures and tests and measurements specify that the direct (1-on-1) time spent in patient contact is 15 minutes.

Providers report procedure codes for services delivered on any calendar day using CPT® codes and the number of service units.

Providers must document in the treatment note the amount of time spent for each time based code billed.

For any single CPT® code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes.

If the duration of a single modality or procedure is greater than or equal to 23 minutes and less than 38 minutes, then 2 units must be billed. Time intervals for the number of units are as follows:

Units Reported on the Claim	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥113 minutes to < 128 minutes

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

If more than 1 CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

Report the duration of treatment for each timed code billed in the daily treatment note.

Example 1

On the same day you provide:

- 24 minutes of neuromuscular reeducation (CPT® code 97112) and
- 23 minutes of therapeutic exercise (CPT® code 97110).

Total treatment time is 47 minutes. A maximum of 3 units can be billed.

The correct coding is 2 units of CPT® code 97112 and 1 unit of CPT® code 97110, assigning more units to the service that took the most time.

Example 2

On the same day you provide:

- 5 minutes of ultrasound (CPT® code 97035) and
- 6 minutes of manual therapy (CPT® code 97140) and
- 10 minutes of therapeutic exercise (CPT® code 97110)

The total treatment time is 21 minutes. A maximum of 1 unit can be billed.

The correct coding is 1 unit of CPT® code 97110 (the service provided for the longest time).

The clinical record will serve as documentation that the other 2 services were also performed.

Prohibited Pairs

A therapist cannot bill any of the following pairs of CPT® codes for outpatient therapy services provided simultaneously to 1 or more patients for the same time period.

- Any 2 CPT® codes for "therapeutic procedures" requiring direct, 1-on-1 patient contact.
- Any 2 CPT® codes for modalities requiring "constant attendance" and direct, 1-on-1 patient contact.
- Any 2 CPT® codes requiring either constant attendance or direct, 1-on-1 patient contact—as described above—. For example: any CPT® codes for a therapeutic procedure with any attended modality CPT® code.
- Any CPT® code for therapeutic procedures requiring direct, 1-on-1 patient contact with the group therapy CPT® code. For example: CPT® code 97150 with CPT® code 97112.
- Any CPT® code for modalities requiring constant attendance with the group therapy code. For example: (CPT® code 97150 with CPT® code 97035)
- Any untimed evaluation or reevaluation code with any other timed or untimed CPT® codes, including constant attendance modalities, therapeutic procedures and group therapy.

DETERMINING WHAT TIME COUNTS TOWARDS 15-MINUTE TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intraservice care" begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (For example, on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant or 2 therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only 1 unit of the appropriate CPT® code. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services will not be exceeded.

WORK HARDENING AND WORK CONDITIONING

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker. Work hardening programs require prior approval by the worker's attending physician and **prior authorization** by the claim manager.

Only L&I approved work hardening providers will be paid for work hardening services.

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on L&I's web site at http://www.LNI.wa.gov/ClaimsIns/Providers/Manage/RTW/WorkHard/default.asp

This information is also available by calling the Provider Hotline at 1-800-848-0811 or the work hardening program reviewer at (360) 902-4480.

The work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT® codes 97545 and 97546. These codes are subject to the following limits:

Work hardening programs are authorized for up to 4 weeks.

Code	Description	Unit limit (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	$ 117.02
97545	Initial 2 hours per day	20 units per program; max.1unit per day per claimant (1 unit = 2 hours)	$ 125.52
97546	Each additional hour	70 units per program; add-on, will not be paid as a stand-alone procedure per claimant per day. (1 unit = 1 hour)	$ 59.07

Program extensions

Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension up to 2 additional weeks. Additional units available for extended programs

Code	Description	6 week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial 2 hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences is **not covered** as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using procedure codes 97545 and 97546.

Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

Billing for less than 2 hours of service in 1 day (97545)

Services provided for less than 2 hours on any day do not meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of 4 hours per day, increasing each week to 7-8 hours per day by week 4.

Billing less than 1 hour of 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount prorated to reflect the reduced level of service. For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only 1 unit of 97545 (first 2 hours) will be paid per day per claimant and the total number of hours billed should not exceed the number of hours of direct services provided.

Example: The occupational therapist (OT) is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist (PT) is responsible for. The 6 hours of services could be billed in 1 of 2 ways.

Option 1		
PT	1 unit 97545	2 hours
OT	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
OT	1 unit 97545 + 2 units 97546	2 hours 2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

Billing for evaluation and treatment on the same day – multiple disciplines

If both the OT and the PT need to bill for 1 hour of evaluation and 1 hour of treatment on the same date of service, the services must be billed as follows:

Provider	Service	Bill As:
OT	1 hour evaluation	1 unit 1001M
PT	1 hour evaluation	1 unit 1001M
OT (or PT)	1 hour treatment	1 unit 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour treatment	1 unit 97546

Work Conditioning

L&I does not recognize work conditioning as a special program. Work conditioning is paid according to the rules for outpatient physical and occupational therapy. See WAC 296-23-220 and WAC 296-23-230.

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 is **not covered** for osteopathic physicians.

For OMT services body regions are defined as:

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Rib cage
- Abdomen and viscera regions
- Lower and upper extremities

These codes ascend in value to accommodate the additional body regions involved. Therefore, only 1 code is payable per treatment. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the –25 modifier.

The insurer **will not pay** for E/M codes billed on the same day as OMT without the –25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers may bill professional services for application of stimulators with the CPT® physical medicine codes when it is within the provider's scope of practice. Attending doctors who are not board qualified or certified in physical medicine and rehabilitation must bill local code 1044M.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described as follows.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Prior authorization is required
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
L8680	Implantable neurostimulator electrode	UW study only
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.
E0761	Nontherm electromgntc device	Covered
E0762	Trans elec jt stim dev sys	Not covered
E0764	Functional neuromuscular stimulator	Prior authorization is required
E0765	Nerve stimulator for tx n&v	Not covered
E0769	Electric wound treatment dev	Not covered

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5120	Skin barrier wipes box per 50	
A6250	Skin seal protect moisturizer	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

The Medical Treatment Guidelines Subcommittee of the Washington State Medical Association reviewed literature on the effectiveness of TENS units in treating pain. There is evidence the units can be effective in treating acute or postoperative pain. However, there is less evidence the devices are effective in treating chronic pain. In particular, it is unusual for a patient to benefit from a TENS unit for more than 3 months.

Prescribing TENS

Providers, both in and out-of-state, who prescribe or dispense TENS units for State Fund workers, per WAC 296-23-165(1) (b), must use L&I's contracted vendor:

Empi, Inc.

19625 62nd Avenue South Suite A-101

Kent, WA 98032-1106

Phone: (253) 852-0078

(800) 999-TENS (800) 999-8367, for local assistance Ex. 6821

Fax: (253) 852-0427

TENS units may be prescribed by licensed

- Medical physicians
- Osteopathic physicians
- Naturopathic physicians
- Podiatric physicians
- ARNPs
- Dental surgeons
- Physician assistants

These providers can also sign the TENS Purchase Recommendation form.

Licensed chiropractors (DCs) licensed in Washington are not allowed to prescribe TENS units according to WAC 246-808-640. Out-of-state chiropractors can usually prescribe TENS units for State Fund workers who do not live in Washington. This is based upon their scopes of practice in their states.

NOTE: Physical and occupational therapists may only fit workers with TENS units upon referral by the provider types listed above.

Services Provided by Empi

Empi has technical specialists who provide assistance regarding the TENS models available through the contract. In addition, Empi provides customer service that supports both workers and providers.

Some services provided by Empi's technical, customer service, and quality programs include:

- Technical instructions to individual clinics and providers on an as-needed basis;
- Training to individual or groups of Washington TENS providers. During the training sessions, Empi will, at a minimum, present information about the contracted TENS units, supplies, and services provided under L&I's TENS contract. Hands-on training for all the TENS units in the contract will also be provided;
- Visits to clinics with inventories of TENS units and supplies at least every 6 weeks;
- Provides a toll-free number for providers and workers with questions and requests for more information;
- Provides follow-up calls to new TENS patients to ensure they understand how to properly use the unit and accessories;
- Meets the needs of workers whose primary language is not English; and
- In exceptional circumstances, will be available to provide at-home instruction and assistance to TENS patients.

Dispensing TENS

Providers may have on-site inventories of the TENS units included in L&I's TENS contract with Empi, or may order a TENS unit from Empi by calling 1-800-999-TENS (1-800-999-8367).

- In special cases L&I's medical director or designee may approve requests for TENS units that are not listed in the contract. The units must be obtained through Empi.
- Additional TENS units and updated TENS unit models may be added to the contract with L&I's approval.

Providers who maintain an inventory of TENS units must notify Empi when they have dispensed a unit and Empi will replenish the inventory. For those providers who do not have inventories of TENS units, contact Empi and a unit will be express mailed, most often within 1 day of the request.

Electrotherapy standards are set by the U.S. Food and Drug Administration (FDA 510(k) and classified into 3 categories:

- TENS units
- Interferential current stimulators
- Neuromuscular stimulators

L&I's definition of TENS therapy includes TENS units and interferential current stimulators. Neuromuscular stimulators do not fall under the TENS definition.

Providers may prescribe and dispense the following TENS units:

MANUFACTURER	TENS UNIT
American Imex	MicroCare II
American Imex	Premier AP
Empi/Rehabilicare	ProMax
Empi/Rehabilicare	Select
Empi/Rehabilicare	Maxima
Empi/Rehabilicare	Infinity IF(1)
Empi	Epix VT
Empi	Epix XL

(1) This unit is classified by the FDA as a true interferential current stimulator. Only the interferential unit listed in the Empi contract with L&I is eligible for rental and purchase on an at-home basis. Interferential units must be obtained from Empi.

TENS Instruction

L&I allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. This service must be billed with CPT® code 64550.

Trial Evaluation Period

A provider may dispense a TENS unit to a worker for a free trial evaluation period. Prior authorization is not required for the trial evaluation.

The trial evaluation period begins when the TENS unit is dispensed and may last up to 30 days. During the trial evaluation period, the provider and the worker assess whether the TENS treatment is working and if rental of the unit is medically necessary.

RENTAL AND PURCHASE OF TENS

TENS rental or purchase requires authorization by L&I, per WAC 296-20-03001(9),

WAC 296-20-1102 and WAC 296-23-165(3). Vendors who attempt to bill L&I for TENS units without authorization will not be paid.

Rental Period

L&I requires a 30-day trial evaluation period before TENS rental will be considered.

If the TENS unit is beneficial during the trial evaluation period, Empi will request authorization for a 4-month rental period. If authorized, the 4-month authorization is dated from the day the TENS unit was initially dispensed for the trial evaluation.

Providers may request authorization for rental of a TENS unit by contacting Empi at

1-800-999-TENS (1-800-999-8367).

Purchase

L&I requires a 4-month rental period before TENS purchase will be considered.

After a TENS unit has been rented for 3 months, Empi will send a *TENS Purchase Recommendation* form to the prescribing provider.

At the end of the 4-month rental period, the prescribing provider must decide whether or not to pursue purchasing a TENS unit for the worker. If a worker continues to exhibit substantial, measurable improvement as a direct result of TENS therapy, the prescribing provider may request purchase of the unit by completing the *TENS Purchase Recommendation* form (see Requesting Purchase of a TENS unit below for details).

If the prescribing provider does not believe purchase of the TENS unit will be of benefit to the worker, the prescribing provider must check box 12 on the *TENS Purchase Recommendation* form, sign and return it to Empi.

L&I will purchase only 1 TENS unit per claim unless:

- The worker's TENS unit is worn out, obsolete, or not repairable;
- A replacement TENS unit with improved and/or more advanced technology will substantially benefit the worker;
- The worker's medical condition has changed sufficiently to warrant another attempt at TENS therapy after an initial failed attempt.

If a worker's claim is ready for closure prior to the completion of 4 months of TENS rental, the claim manager may authorize early purchase of the TENS unit if TENS therapy is determined to be beneficial.

Requesting Purchase of a TENS Unit:

If the prescribing provider decides that purchase of the TENS unit will benefit the worker, the prescribing provider should request purchase by:

1. Completing the *TENS Purchase Recommendation* form.
2. Sending the form back to Empi.
3. Empi will forward your request to L&I.
4. An L&I medical consultant or his or her designee will review your request and provide a medical perspective as to whether the request is substantiated by the objective medical evidence included on the form.
5. After the medical consultant or his or her designee has completed the TENS purchase review, Empi will contact the L&I Provider Hotline to request authorization for TENS unit purchase.
6. The purchase decision will be communicated to Empi. If L&I denies TENS purchase, Empi will contact the requesting provider and worker.

NOTE: Prescribing providers are not permitted to bill L&I for completion of the *TENS Purchase Recommendation* form.

Denial and Second Purchase Review

If the TENS unit purchase request is denied and the prescribing provider and worker disagree with L&I's decision, the provider may submit a written request for a second purchase review.

The second purchase review must be submitted to Empi and must include additional objective information supporting both the worker's functional improvement and the effectiveness of TENS therapy. Empi will submit the second purchase request to L&I for consideration and will notify the provider and the worker of L&I's authorization decision.

When a TENS Unit is No Longer Authorized

Per RCW 51.28.020 and WAC 296-20-020, a worker with an accepted claim with L&I is entitled to benefits and may not be charged for any costs of treatment deemed appropriate for that claim. This includes postage for any items returned by mail.

When a TENS unit is no longer authorized by L&I, Empi will contact the prescribing provider and worker by letter, notifying them the TENS unit must be returned. All TENS units come with a postage paid, self-addressed package for easy return. If the worker should lose the return packaging, Empi will send replacement packaging at no charge.

The worker's TENS unit is owned by Empi. If the unauthorized TENS unit is not returned to Empi, Empi can bill the worker for all charges related to TENS rental, purchase, supplies and repair that accrue after TENS authorization is denied by L&I.

TENS Supplies and Batteries

L&I **will pay** for medically necessary supplies and batteries for the life of the TENS unit if it has authorized the worker's use of the TENS unit for an accepted condition. All supplies and batteries must be obtained from Empi.

TENS Unit Repair and Replacement

TENS units dispensed on or after January 1, 2003, have a 5-year warranty as long as the unit is being used by the original purchaser. TENS units dispensed prior to that date are no longer under warranty. Regardless of warranty status, TENS unit repair is a **covered** service as long as the damage to the TENS unit has not been caused by worker abuse, neglect or misuse. L&I and Empi, at their discretion, will decide when or if to repair a TENS unit or replace it with a TENS unit comparable to the original unit. In cases where damage to the TENS unit is due to worker abuse, neglect or misuse, TENS unit repair or replacement is the responsibility of the worker. Replacement of a lost or stolen TENS unit is also the responsibility of the worker.

The TENS vendor is responsible for warranty-covered TENS repair or replacement. TENS warranty covers defects in workmanship and materials, including parts and labor. The vendor can decide when or if to repair a TENS unit or replace it with the same TENS unit or a TENS unit comparable to the damaged unit.

L&I is responsible for nonwarranty covered TENS unit repair or replacement. Nonwarranty covered repair includes repair needed because of normal wear or a work related incident that damaged the unit. Nonwarranty repair or replacement must be arranged through the TENS vendor. L&I can decide when or if to repair a TENS unit or replace it with the same TENS unit or a TENS unit comparable to the damaged unit.

TENS Billing Codes

L&I's contracted vendor and providers treating self-insured workers must use the appropriate HCPCS codes to bill for TENS units and supplies. Sales tax and delivery charges are not separately payable and must be included in the total charge for the TENS unit and supplies.

HCPCS Code	Brief Description	Coverage Status
A4595	TENS Supp 2 lead per month	For State Fund claims: Payable to L&I's contracted TENS vendor. For self-insured claims: Payable to DME suppliers.
A4630	Repl batt TENS own by pt	
E0730	TENS, 4 lead	

Additional supply codes that may be billed by L&I's contracted vendor and DME suppliers for self-insured claims.

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive Remover Wipes, any type, per 50	Payable for home use
A4450	Tape, nonwaterproof, per 18 square inches	
A4452	Tape, waterproof, per 18 square inches	
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce	
A4556	Electrodes, (For example, apnea monitor), per pair	
A4557	Lead wires, (For example, apnea monitor), per pair	
A4558	Conductive paste or gel	
A5120	Skin barrier, wipes or swabs, each	
A5126	Adhesive or non adhesive; disk or foam pad	
A6250	Skin sealants, protectorants, moisturizers, ointments, any type, any size	
E1340	Repair or nonroutine service for durable medical equipment requiring the skills of a technician, labor component, per 15 minutes.	
E1399	DME equipment, miscellaneous	

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, they must use the appropriate CPT® codes for radiology, office visits and case management services and HCPCS codes for miscellaneous materials and supplies.

EVALUATION AND MANAGEMENT

Chiropractic physicians may bill the first 4 levels of new and established patient office visit codes. L&I uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last 3 years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is **payable only once** for the initial visit.
- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require **prior authorization**.
- Modifier –22 is **not payable** with E/M codes for chiropractic services.
- Established patient E/M codes are **not payable** in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Case Management

Refer to Case Management Services, page **36**, in the Evaluation and Management section for information on billing for case management services. These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first 4 levels of CPT® office consultation codes. L&I periodically publishes:

- A policy on consultation referrals and
- A list of approved chiropractic consultants

The most recent policy,list of approved consultants and how to become a chiropractic consultant is available on the L&I web at

http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/Chiro/chiroConsult.asp

Physical Medicine Treatment

Local code 1044M (physical medicine modality (ies) and/or procedure(s) by attending doctor not board qualified/certified in PM&R) may be billed up to 6 times per claim (not per attending doctor). Refer to the previous section Non-Board Certified/Qualified Physical Medicine providers, page **59** for more information. Documentation of the visit must support billing for this procedure code.

CPT® physical medicine codes 97001-97799 are not payable to chiropractic physicians.

Powered Traction Devices

Powered traction devices are **covered** as a physical medicine modality under existing physical medicine payment policy. The insurer will not pay any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. When powered traction is a proper and necessary treatment, the insurer may pay for powered traction therapy administered by a qualified provider. Nonboard certified/qualified physical medicine providers must use 1044M. Therapy is **limited to 6 visits** except when the doctor practices in a remote area.

Only 1 unit of the appropriate billing code will be paid per visit, regardless of the length of time the treatment is applied. For additional information see "Powered Traction Therapy", page **61**, in the Physical Medicine section of this document.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. L&I defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service. Examples of patient education or counseling include discussion about:

- Lifestyle
- Diet
- Self-care and activities of daily living
- Exercise instruction involving a provision of a sheet of home exercises

CHIROPRACTIC CARE VISITS

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. CPT® codes for chiropractic manipulative treatment (98940-98943) **are not covered**. L&I collaborated with the Washington State Chiropractic Association and the University of Washington to develop local codes for chiropractic services. The codes account for these components of treating workers:

- professional management (clinical complexity), and
- technical (manipulation and adjustment)

Local codes for chiropractic care visits.

2050A	Level 1: Chiropractic Care Visit (straightforward complexity)	$ 41.20
2051A	Level 2: Chiropractic Care Visit (low complexity)	$ 52.76
2052A	Level 3: Chiropractic Care Visit (moderate complexity)	$ 64.29

Clinical complexity is similar to established patient evaluation and management services, but emphasizes factors typically addressed with treating workers. Factors that contribute to visit complexity include:

- The current occupational condition(s)
- Employment and workplace factors
- Nonoccupational conditions that may complicate care of the occupational condition
- Chiropractic intervention(s) provided (including the number of body regions manipulated)
- Care planning and patient management
- Response to care

Note: The number of body regions being adjusted is only one of the factors that may contribute to visit complexity.

Payment Policies for Chiropractic Care Visits

- **Only 1** chiropractic care visit code is payable per day.
- Extremities are considered as one body region and are **not billed separately**.
- Office visits in excess of 20 visits or 60 days require **prior authorization** per WAC 296-20-03001(1).
- Modifier –22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). Submit a report detailing the nature of the unusual service and the reason it was required. Payment will vary based on the review findings. This modifier is **not payable** when used for noncovered or bundled services (for example: application of hot or cold packs).

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit CPT® codes (99201-99204, 99211-99214) **only when all of the following conditions are met:**

- The E/M service is for the initial visit on a new claim; and
- The E/M service constitutes a significant, separately identifiable service (exceeds the usual pre- and post-service work included in the chiropractic care visit); and
- Modifier –-25 is added to the patient E/M code; and
- Supporting documentation describing the service(s) is in the patient's record.

Billing Tip

When a patient requires reevaluation for an existing claim:

- Either an established patient E/M code OR
- A chiropractic care local code (2050A-2052A) is payable.

Modifier –25 is not applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the 3 levels of chiropractic care visits. Clinical decision making complexity is the primary component in selecting the level of the visit. L&I defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

	Primary Component influencing level of care	**Other Components that may affect level of care**	
	Complexity of clinical decision making	**Typical number of body regions(1) manipulated**	**Typical face to face time with patient and/or family**
Level 1 (2050A)	Straightforward	Up to 2	Up to 10-15 minutes
Level 2 (2051A)	Low complexity	Up to 3 or 4	Up to 15-20 minutes
Level 3 (2052A)	Moderate complexity	Up to 5 or more	Up to 25-30 minutes

(1) Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint)
- Thoracic (includes costovertebral and costotransverse joints)
- Lumbar
- Sacral
- Pelvic (includes sacro-iliac joint)
- Extraspinal: Any and all extraspinal manipulations are considered to be **one region**. Extraspinal manipulations include
- Head (including temporomandibular joint, excluding atlanto-occipital)
- Lower extremities
- Upper extremities
- Rib cage (excluding costotransverse and costovertebral joints)

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 Chiropractic Care Visit (straightforward complexity)	26-year-old male presents with mild low back pain for several days after lifting a box at work. He receives manipulation/adjustment of the lumbar region, anterior thoracic mobilization and lower cervical adjustment.
Level 2 Chiropractic Care Visit (low complexity)	55-year-old male presents for follow up with ongoing complaints of neck pain and lower back pain which occurred after he slipped and fell near the bottom of a stairwell while carrying a printer at work. Today, worker reports new sensation of periodic tingling in right foot. He was off work for 2 days. Intervention includes discussion of minimizing lifting and getting assistance with heavier objects. Worker receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.
Level 3 Chiropractic Care Visit (moderate complexity)	38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. She tried to return to light duty last week, but was unable to sit for very long and went home. She is obese and mentioned in her history that she might have borderline diabetes. MRI report was received today and reviewed with the worker. Worker reports she tried to do the stretching prescribed during her last visit but they hurt so she did not do them. She receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

CHIROPRACTIC INDEPENDENT MEDICAL EXAMS

Chiropractic physicians must be approved examiners by the department prior to performing independent medical exams (IMEs). In order to apply for approval chiropractic physicians must meet the following requirements:

- Complete two years chiropractic consultant;
- Complete an impairment rating course approved by the department; or
- Complete a Chiropractic Consultant Seminar during the previous 24 months.

Both of the above mentioned courses are offered as part of the Chiropractic Consultant Program. For more information refer to the *Medical Examiners' Handbook* (publication F252-001-000).
http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/IME/MedHandbook/default.asp.

Attending doctor chiropractic physicians performing impairment ratings on their own patients or approved consultants upon referral should refer to page **87**, later in this section.

CHIROPRACTIC RADIOLOGY SERVICES

Chiropractic physicians must bill diagnostic X-ray services using CPT® radiology codes and the policies described in the Radiology Services section, page **57**.

If needed, X-rays immediately prior to and following the initial chiropractic adjustment **are allowed** without prior authorization when medically necessary. X-rays subsequent to the initial study require **prior authorization**.

Only chiropractic physicians who are on L&I's list of approved radiological consultants may bill for X-ray consultation services. To qualify, a chiropractic physician must be a Diplomat of the American Chiropractic Board of Radiology and must be approved by L&I.

SUPPLIES

See the Supplies, Materials and Bundled Services section, page **116** to find information about billing for supplies.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply only to workers covered by the State Fund and self-insured employers (see WAC 296-21-270). Refer to the Medical Treatment Guideline for Psychiatric and Psychological Evaluation at http://www.LNI.wa.gov/ClaimsIns/Files/OMD/MedTreat/PsychEval.pdf for information on:

- Treatment guidelines
- Psychiatric conditions
- Reporting requirements
- Diagnosis of a psychiatric condition
- Identifying barriers that hinder recovery from an industrial injury
- Formulation of a psychiatric treatment plan
- Assessment of psychiatric treatment and recommendations

For information on psychiatric policies applicable to the Crime Victims' Compensation Program, refer to http://www.lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/Default.asp and Chapter 296-31 WAC.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by either a psychiatrist (MD or DO) or a licensed psychologist (PhD), (see WAC 296-21-270).

Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors, **are not covered** even when delivered under the direct supervision of a clinical psychologist or a psychiatrist.

Staff supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing; however, the psychiatrist or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS AS ATTENDING PHYSICIANS

A psychiatrist can only be a worker's attending physician when the insurer has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist may certify a worker's time loss from work if a psychiatric condition has been allowed and the psychiatric condition is the only condition still being treated. A psychiatrist may also rate psychiatric permanent partial disability.

Psychologists cannot be the attending provider and may not certify time loss from work or rate permanent partial disability per WAC 296-20-01002 (Doctor).

NONCOVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services **are not covered:**

CPT® Code	CPT® Code
90802	90845
90810-90815	90846
90823-90829	90849
90857	

The following services are bundled and **are not payable separately:**

CPT® Code
90885
90887
90889

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

Prior authorization is required for all psychiatric care referrals (see WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist, they may bill either the E/M consultation codes or the psychiatric diagnostic interview exam code.

When an authorized referral is made to a clinical psychologist for an evaluation, they may bill only CPT® code 90801.CPT® code 90801 is limited to 1 occurrence every 6 months, per patient, per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

Telephone psychology services are **not covered**. Refer to the Teleconsultation Section, page **39** for further details.

CASE MANAGEMENT SERVICES

Psychiatrists and clinical psychologists may only bill for case management services when providing consultation or evaluation.

For payment criteria and documentation requirements, see Case Management Services in the Evaluation and Management section, page **36**.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into:

- Services with an E/M component, and
- Services without an E/M component.

Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes (CPT® 90804-90809, 90816-90819, 90821-90822) either with or without an E/M component.

Psychotherapy with an E/M component may be billed when other services are conducted along with psychotherapy such as:

- Medical diagnostic evaluation,
- Drug management,
- Writing physician orders,
- Interpreting laboratory or other medical tests.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component. They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of a clinical psychologist's license.

Further explanation of this policy and CMS's response to public comments are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997. This is available on line at http://www.gpoaccess.gov/fr/index.html.

To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, do not bill more than 1 unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists may **only** bill the E/M codes for office visits on the same day psychotherapy is provided **if** it's medically necessary to provide an E/M service for a condition other than that for which psychotherapy has been authorized. The provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation is payable only to psychiatrists. If a pharmacological evaluation and psychotherapy are conducted on the same day, then the psychiatrist bills the appropriate psychotherapy code with an E/M component.

In this case, the psychiatrist must not bill the individual psychotherapy code and a separate E/M code (CPT® codes 99201-99215). Payment **is not allowed** for psychotherapy and pharmacological management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is **not payable with**:

- CPT® code 90862
- CPT® E/M office visit or
- Consultation codes (CPT® codes 99201-99215, 99241-99275).

HCPCS code M0064 is described "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders."

It is paid only if these described conditions are accepted or treatment is temporarily allowed by the insurer.

NEUROPSYCHOLOGICAL TESTING

The following codes may be used when performing neuropsychological evaluation. Reviewing records and/or writing/submitting a report is included in these codes and may not be billed separately.

CPT® Code	May be billed:
90801	Once every 6 months per patient per provider.
96101 and 96102	Up to a combined 4 hour maximum. In addition to CPT® codes 96118 and 96119.
96118 and 96119	Per hour up to a combined 12 hour maximum.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment is authorized on a case-by-case basis only. If authorized, the worker may participate in group therapy as part of the individual treatment plan. The insurer does not pay a group rate to providers who conduct psychotherapy exclusively for groups of workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

CPT® codes 90865 and 90870 require **prior authorization**. Authorized services are payable only to psychiatrists because the therapy requires administration of medication.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order and **prior authorization**. Refer to WAC 296-20-03001 for information on what to include when requesting authorization.

Home biofeedback device rentals are time limited and require **prior authorization**. Refer to WAC 296-20-1102 for the insurers' policy on rental equipment.

Biofeedback treatment is limited to those procedures within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also has authorization conditions, treatment limitations and reporting requirements for biofeedback services.

A qualified or certified biofeedback provider as defined in WAC 296-21-280 who is not licensed as a practitioner as defined in WAC 296-20-01002, may not receive direct payment for biofeedback services. Services may be provided by paraprofessionals as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed along with individual psychotherapy:

Bill using either CPT® code 90875 or 90876.

Do not bill CPT® codes 90901 or 90911 with the individual psychotherapy codes.

The following contains the biofeedback codes for approved providers:

CPT®/HCPCS Code	Payable to:
90875	L&I approved biofeedback providers who are: clinical psychologists or psychiatrists (MD or DO).
90876	
90901(1)	Any L&I approved biofeedback provider
90911(1)	
E0746	DME or pharmacy providers (for rental or purchase). Use of the device in the office is not separately payable for RBRVS providers.

(1) CPT® codes 90901 and 90911 are not time limited and only 1 unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use evaluation and management codes for diagnostic evaluation services.

ELECTROMYOGRAPHY (EMG) SERVICES

Payment for needle electromyography (EMG) services is limited as follows:

CPT® Code	Limitations
95860 95861 95863 95864	• Extremity muscles innervated by 3 nerves or 4 spinal levels must be evaluated with a minimum of 5 muscles studied. • **Not payable** with CPT® code 95870
95869	• May be billed alone (for thoracic spine studies only) • Limited to 1 unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied it is not payable separately.
95870	• Limited to 1 unit per extremity and 1 unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. • **Not payable** with extremity codes (5 units maximum payable)

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included.

These services may be paid along with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are **not payable with** office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is **not separately payable**.

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The insurer **does not cover** extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature. Additional information can be found at

http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/ESWT.asp

VENTILATOR MANAGEMENT SERVICES

The insurer **does not pay** for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider.

The insurer **pays** for either the ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code and an E/M service for the same day, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

See WAC 296-20-03005 for work-related exposure to an infectious disease. Immunization materials are payable when authorized.

CPT® codes 90471 and 90472 **are payable** in addition to the immunization materials code(s).

Add-on CPT® code 90472 **is limited** to a maximum of 1 unit per day.

An E/M code is **not payable** in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a –25 modifier.

Information on bloodborne pathogens can be found at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/CovmedDev/SpecCovDec/bloodbornePath.asp

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes **are not paid**. The provider bills 1 of the injection codes and 1 of the antigen/antigen preparation codes.

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service.

> **Exception:** Outpatient services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, services (CPT® codes 90760, 90761, 90765-90768) **are payable** to physicians, ARNPs, and PAs.
>
> Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 90773 and 90774) will **not be paid separately** in conjunction with the IV infusion codes.
>
> Durable Medical Equipment (DME) providers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account numbers. Call the Provider Hotline at 1-800-848-0811.

Refer to the Home Infusion Services section, page 116 for further information on home infusion therapy.

Providers will be paid for E/M office visits in conjunction with infusion therapy only if the services provided meet the code definitions.

Billing instructions for nonpharmacy providers are located in Injectable Medications, page **83** later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service.

If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the Home Health Services section, page **113** for further information.

The insurer **may cover** with **prior authorization:**

- Implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786).
- The implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal.
- Antispasticity medications by any indicated route of administration when spinal cord injury is an accepted condition (for example, some benzodiazepines, Baclofen).

Placement of nonimplantable epidural or subarachnoid catheters for single or continuous injection of medications **is covered**.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are **not covered** (see WAC 296-20-03002).

Infusion of any opiates and their derivatives (natural, synthetic or semisynthetic) are **not covered unless** they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see WAC 296-20-03014).

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 90772) **are payable** along with the appropriate HCPCS **J** code for the drug.

E/M office visit services provided on the same day as an injection **may be payable** if the services are separately identifiable.

Separate E/M services (CPT® codes 99212-99215) **may be billed** using a –25 modifier.

CPT® code 99211 will **not be paid** separately and, if billed with the injection code, providers will be **paid only** the E/M service and the appropriate HCPCS **J** code for the drug.

Providers must document the following in the medical record and in the remarks section of the bill:

- Name,
- Strength,
- Dosage and
- Quantity of the drugs administered

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 90773 and 90774) may be billed separately and **are payable** if they are not provided in conjunction with IV infusion therapy services (CPT® codes 90760, 90761, 90765-90768).

> **NOTE***:* Injections of narcotics or analgesics are **not permitted** or paid in the outpatient setting except:
>
> - On an emergency basis (see WAC 296-20-03014)
> - For pain management related to outpatient surgical procedures and dressing and cast changes
> - For severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications.

Dry needling is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. Dry needling of trigger points must be billed using CPT® codes 20552 and 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

The insurer **does not cover** acupuncture services (see WAC 296-20-03002). Additional coverage decision information can be found online at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/acupuncture.asp

Injectable Medications

Providers must use the **J** codes for injectable drugs that are administered during an E/M office visit or other procedure.

The **J** codes are not intended for self-administered medications.

When billing for a non-specific injectable drug the following must be noted on the bill and documented in the medical record:

- Name,
- Strength,
- Dosage and
- Quantity of drug administered or dispensed.

Providers must bill their acquisition cost for the drugs.

L&I fees for injectable medications are based on the AWP and the drug strengths listed in the HCPCS manual. Divide the total strength of the injected drug by the strength listed in the manual to get the total billable units.

For example:

1. You administer a 100 mg injection.
2. The HCPCS manual lists the strength as 10 mg.
3. Your billable units are 100 mg (administered) divided by 10 mg (strength) = 10 units

Payment is made according to the published fee schedule amount, or the billed charge for the **covered** drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are **only allowed** for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid, see WAC 296-20-03002(6).

Hyaluronic acid injections must be billed with CPT® code 20610 and the appropriate HCPCS code.

HCPCS Code	Description	Maximum Fee
J7321	Hyalgan or Supartz inj	$101.32
J7322	Synvisc, inj	$228.38
J7323	Euflexxa, inj	$137.79
J7324	Orthovisc, inj	$235.22

The correct side of body modifier (–RT or –LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each billed as a separate line item.

See more information on hyaluronic acid injections at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/HyAcid.asp

Non-Injectable Medications

Providers may use distinct **J** codes that describe specific noninjectable medication administered or dispensed for short-term use until the worker can have prescriptions filled at a pharmacy. Separate payment will be made for these medications. The name, strength, dosage and quantity of the drug administered or dispensed must be documented in the medical record and noted on the bill.

Providers must bill their acquisition cost for these drugs. See the Acquisition Cost Policy in the Supplies, Materials and Bundled Services section, page **117** for more information.

Miscellaneous oral or noninjectable medications administered during office procedures or dispensed for short-term use are considered bundled in the office visit. No separate payment will be made for these medications. The name, strength, dosage and quantity of drug administered or dispensed must be documented in the medical record

The non-specific HCPCS codes listed below are bundled in the office visit.

HCPCS Code	Brief Description
A9150	Nonprescription drug
J3535	Metered does inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Noninhalation drug for DME
J8498	Antiemetic drug, rectal/suppository, nos
J8499	Oral prescript drug nonchemo
J8597	Antiemetic drug, oral, nos
J8999	Oral prescription drug chemo

No payment will be made for pharmaceutical samples.

OBESITY TREATMENT

Obesity does not meet the definition of an industrial injury or occupational disease.

Temporary treatment may be allowed when the unrelated obesity condition hinders recovery from an accepted condition.

Services for all obesity treatment **require prior authorization**.

To be eligible for obesity treatment, the worker must be severely obese. Severe obesity for the purposes of providing obesity treatment is defined by L&I as a Body Mass Index (BMI) of 35 or greater.

The attending doctor may request a weight reduction program if the worker meets all of the following criteria:

- Is severely obese; and
- Obesity is the primary condition retarding recovery from the accepted condition; and
- The weight reduction is necessary to:
  - Undergo required surgery, or
  - Participate in physical rehabilitation, or
  - Return to work.

An attending doctor who believes a worker may qualify for obesity treatment should contact the insurer. The attending doctor will need to advise the insurer of the worker's weight and level of function prior to the injury and how it has changed.

The attending doctor must submit medical justification for obesity treatment, including tests, consultations or diagnostic studies that support the request.

The attending doctor may request a consultation with a certified dietitian (CD) to determine if an obesity treatment program is appropriate for the worker.

Only CDs will be paid for nutrition counseling services. CDs may bill for authorized services using CPT® code 97802 or 97803. Both CPT® 97802 and 97803 are billed in 15 minute units.

CPT® Code	Limit	Maximum Fee per unit
97802	Initial visit, maximum of 4 units	$ 46.76
97803	Maximum 2 units per visit with maximum of 3 visits	$ 41.23

Providers practicing in another state that are similarly certified or licensed may apply to be considered for payment.

Prior to authorizing an obesity treatment program, the attending doctor and worker are required to develop a treatment plan and sign an authorization letter. This authorization letter will serve as a memorandum of understanding between the insurer, the worker and the attending doctor. The treatment plan will include:

- The amount of weight the worker must lose to undergo surgery.
- Estimated length of time needed for the worker to lose the weight.
- A diet and exercise plan, including a weight loss goal, approved by the attending doctor as safe for the worker.
- Specific program or other weight loss method requested.
- The attending doctor's plan for monitoring weight loss.
- Documented weekly weigh-ins.
- Group support facilitated by trained staff.
- Counseling and education provided by trained staff.
- No requirements to buy supplements or special foods.

The insurer does not pay for:

- Surgical treatments of obesity (for example, gastric stapling or jaw wiring).
- Drugs or medications used primarily to assist in weight loss.
- Special foods (including liquid diets).
- Supplements or vitamins.
- Educational material (such as food content guides and cookbooks).
- Food scales or bath scales.
- Exercise programs or exercise equipment.

Upon approval of the obesity treatment plan, the attending doctor's role is to:

- Examine the worker, monitor and document their weight loss every 30 days.
- Notify the insurer when:
  - The worker reaches the weight loss goal, or
  - Obesity no longer interferes with recovery from accepted condition, or
  - The worker is no longer losing the weight needed to meet the weight loss goal in the treatment plan.

To ensure continued authorization of the obesity treatment plan the worker must do each of the following:

- Lose **an average** of 1 to 2 pounds a week.
- Regularly attend weekly treatment sessions (meetings and weigh-ins).
- Cooperate with the approved obesity treatment plan.
- Be evaluated by the attending doctor at least every 30 days.
- Pay the joining fee and weekly membership fees up front and get reimbursed.

Send the insurer a copy of the weekly weigh-in sheet signed by the program coordinator every week.

The insurer does not pay the obesity treatment provider directly. The worker will be reimbursed for the obesity treatment program using the following codes:

Code	Description	Fee Limits
0440A	Weight loss program, joining fee, worker reimbursement	$154.77
0441A	Weight loss program, weekly fee, worker reimbursement	$30.96

The insurer authorizes obesity treatment for up to 90 days at a time as long as the worker does **all** of the above. The insurer stops authorizing obesity treatment when **any one** of the following occurs:

- The worker reaches the weight loss goal identified in the obesity treatment plan. (The worker may continue the weight loss program for general health at their own expense).
- Obesity no longer interferes with recovery from the accepted condition. (WAC 296-20-055 prohibits treatment of an unrelated condition once it no longer retards recovery from the accepted condition.)
- The worker is not cooperating with the approved obesity treatment plan.
- The worker is not losing weight at **an average** of 1 to 2 pounds each week.

IMPAIRMENT RATING EXAM AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

Attending doctors who are currently licensed in medicine and surgery, osteopathic medicine and surgery, podiatry, dentistry and L&I approved chiropractors may rate impairment of their own patients. Doctors of naturopathy and optometry may not bill these codes per WAC 296-20-2010.

For details on this topic, please refer to the *Medical Examiners' Handbook*, page V-1. To obtain a copy online go to http://www.LNI.wa.gov/IPUB/252-001-000.pdf.

Attending doctors who are permitted to rate their own patients do not need an IME provider account number. They use their existing provider account number and should:

- Request authorization from the claim manager to ensure payment for these services.
- Perform the rating when the worker has reached maximum medical improvement (MMI). This generally occurs during the closing exam where you provide objective measurements. (This is crucial information for later reference if there is worsening. Claim managers will use these measurements when considering re-opening applications.)
- Submit impairment rating reports that include all of the elements of the impairment rating exam (see page V-2 of the *Medical Examiners' Handbook*.) If there is no impairment, please document that in your report.
- Use the appropriate rating system.
- Select the most appropriate billing code.

These L&I specialty codes are for use by attending doctors and consultants performing impairment ratings. Chiropractic consultants performing impairment ratings must be on L&I's list of approved examiners.

Code	Description	Maximum Fee
1190M	Impairment rating by attending physician, limited, requested by the insurer, 1 body area or organ system. Use this code if there is only 1 body area or organ system that needs to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area or organ system. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 439.50
1191M	Impairment rating by attending physician, standard, requested by the insurer, 2-3 body areas or organ systems. Use this code if there are 2-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body area or organ system. • Diagnostic tests are ordered and interpreted. • Impairment rating is performed as requested. • The impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 493.56

Code	Description	Maximum Fee
1192M	Impairment rating by attending physician, complex, requested by the insurer, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Familiarity with the history of the industrial injury or condition. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 616.93
1194M	Impairment rating by consultant, standard, requested by the insurer, 1-3 body areas or organ systems. Use this code if there are 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Records are reviewed. • Physical exam is directed only toward the affected areas or organ systems of the body. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 493.56
1195M	Impairment rating by consultant, complex, requested by the insurer, 4 or more body areas or organ systems. Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). Included in this code are the following requirements: • Records are reviewed. • Physical exam is directed only toward the affected areas or organ systems of the body. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed as requested. • Impairment rating report must contain the required elements noted in the *Medical Examiners' Handbook*. Office visits are considered a bundled service and are included in the impairment rating fee. Definitions of organ systems and body areas can be found in the CPT® manual.	$ 616.93
1198M	Impairment rating, addendum report. Must be requested and authorized by the claim manager. • Addendum report for additional information which necessitates review of new records. • Payable to attending physician or consultant. This code is not billable when the impairment rating report did not contain all the required elements. (See the *Medical Examiners' Handbook* for the required elements.)	$ 113.40

Limited, Standard and Complex Coding

The impairment rating exam should be sufficient to achieve the purpose and reason the exam was requested. Choose the code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of body areas and organ systems from Current Procedural Terminology (CPT®) book must be used to distinguish between limited, standard and complex impairment rating.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining limited, standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

INDEPENDENT MEDICAL EXAMS (IME)

Only doctors with an IME provider account numbers can bill IME codes. To obtain an application, go to http://www.LNI.wa.gov/forms/pdf/245046af.pdf

Or, for Crime Victims contact the Crime Victims Compensation Program Provider Registration desk at 360-902-5377.

For more information on becoming an approved IME provider or to perform impairment ratings, please see the *Medical Examiners' Handbook* at http://www.LNI.wa.gov/IPUB/252-001-000.pdf or go to

http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/IME/BecomeIMEProv/default.asp.

To receive e-mail updates on IMEs, subscribe to the ListServ at http://www.LNI.wa.gov/Main/Listservs/IME.asp .

IME Unique Billing Codes

Code	Description	Maximum Fee
1100M	IME, microfiche handling, initial 10 pages of fiche with referral. • Payable only once per referral. • You may not bill this code if you are provided with a paper copy of the claim record.	$ 58.82
1101M	IME, microfiche handling, per fiche page beyond 10 • 1 unit equals 1 microfiche page. • Use code with associated units only once per referral.	$ 5.89 (per fiche page)
1104M	IME, addendum report. Requested and authorized by claim manager. • Addendum report for information not requested in original assignment, which necessitates review of records. • Not to be used for review of job analysis or review of diagnostic testing or study results ordered by the examiner.	$ 113.40

Code	Description	Maximum Fee
1105M	IME Physical Capacities Estimate. Must be requested by the insurer. Bill under lead examiners's provider account number for multi-examiner exams	$ 30.27
1108M	IME, standard exam – 1-3 body areas or organ systems • Use this code if there are only 1-3 body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). • An appropriate exam and reporting of an injury or condition limited to 1-3 body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition as described in the *Medical Examiners' Handbook.* • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. Impairment rating is performed if requested. • The IME report must contain the required elements noted in the *Medical Examiners' Handbook*. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 30 minutes of face-to-face time with the patient. • This code can be used by: Single examiners, leads on multi-examiner exams where findings from other examiners are combined into 1 report, & examiners on multi-examiner exams who perform separate file review, exam and standalone reports. Additional examiners who are not leads: Use 1112M. **	$ 493.56
1109M	IME, complex exam – 4 or more body areas or organ systems • Use this code if there are 4 or more body areas or organ systems that need to be examined for sufficient evaluation of the accepted condition(s). • An appropriate exam and reporting of an injury or condition of 4 or more body areas or organ systems. • Records are reviewed and the report includes a detailed chronology of the injury or condition, as described in the *Medical Examiners' Handbook*. • Physical exam is directed only toward the affected body areas or organ systems. • Diagnostic tests needed are ordered and interpreted. • Impairment rating is performed if requested. • The report conclusions address how the examined body areas or organ systems relate to the accepted or contended work related injury(s) or condition(s). • The IME report must contain the required elements noted in the *Medical Examiners' Handbook*. • Includes review of up to 2 job analyses. • L&I expects that these exams will typically involve at least 45 minutes of face-to-face time with the patient. • This code can be used by: • Single examiners, • Leads on multi-examiner exams where findings from other examiners are combined into 1 report, & • Examiners on multi-examiner exams who perform separate file review, exam and standalone reports. Additional examiners who are not leads: Use 1112M. **	$ 616.93
1111M	IME, no-show fee, per examiner. • Bill only if appointment time cannot be filled and cancellation is within 3 business days of exam. Business days are Monday through Friday. • Not payable for no-shows of IME related services (for example, neuropsychological evaluations, performance based PCEs).	$ 210.03
1112M	IME, additional examiner for IME • Use where input from more that 1 examiner is combined into 1 report. Includes: • Record review, • Exam, and • Contribution to combined report Note: Lead examiner on IMEs with a combined report should bill a standard or complex	$ 439.50

Code	Description	Maximum Fee
	exam code (1108M or 1109M).	
1118M	IME by psychiatrist • Psychiatric diagnostic interview with or without direct observation of a physical exam. • Includes review of records, other specialist's exam results, if any • Consultation with other examiners and submission of a joint report if scheduled as part of a panel. • Report includes a detailed chronology of the injury or condition, as described in the *Medical Examiners' Handbook.* • Also includes impairment rating, if applicable.	$ 893.15
1120M	IME, no-show fee, psychiatrist • Bill only if appointment time cannot be filled and cancellation is within 3 business days of exam. Business days are Monday thru Friday. • Not payable for no-shows of IME related services (for example, neuropsychological evaluations).	$ 325.56

1122M	Impairment rating by an approved pain program
	• Program must be approved by insurer
	• Impairment rating must be requested by the insurer.
	• Must be performed by a doctor currently licensed in medicine and surgery (including osteopathic and podiatric physicians), dentistry, or L&I approved chiropractic examiners. See WAC 296-20-2010.
	• The rating report must include at least the following elements as described in the *Medical Examiners' Handbook*:
	  • MMI (maximum medical improvement)
	  • Physical exam
	  • Diagnostic tests
	  • Rating
	  • Rationale
		$ 493.56

1123M	IME, communication issues • Exam was unusually difficult due to expressive problems, such as a stutter, aphasia or need for a translator in a case that required an extensive history as described in the report. • Bill once per examiner per exam. • Not payable with a no-show fee (1111M or 1120M).	$ 198.48
1124M	IME, other, by report • Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator.	by report
1125M	Physician travel per mile • Allowed when roundtrip exceeds 14 miles. • Code usage is limited to extremely rare circumstances. • Requires preauthorization and prepay review. For State Fund claims call Provider Review and Education at 360-902-6818. For self-insured claims contact the self-insured employer or third party administrator.	$ 4.84
1128M	Occupational disease history. • Must be requested by insurer. • Occupational carpal tunnel syndrome, noise-induced hearing loss, occupational dermatitis, and occupational asthma are examples of conditions which L&I considers occupational diseases. • The legal standard is different for occupational diseases than for occupational injuries. • This is a detailed assessment of work-relatedness, with the exact content presented in the *Medical Examiners' Handbook.* • A doctor may bill this code ONLY ONCE for each patient.	$ 183.56

Code	Description	Maximum Fee
1129M	IME, extensive file review by examiner • Bill for each additional page beyond the first 550 hardcopy pages included in the base exam fee (1108M, 1109M, 1118M or 1130M). • Units of service are based on the number of hardcopy pages contained on microfiche OR only the following documents contained in the Claim and Account Center, unless the authorizing letter requests a review of ALL documents: • Medical Provider • Voc Rehab Provider • History • Report of Accident • Re-open Application • Bill per examiner. Note- • Review of first 550 hardcopy pages is included with the IME fee. • A detailed chronology of the injury or condition must be included in the report as defined by the Medical Examiners' Handbook. • Not payable with 1111M or 1120M.	$ 1.00
1130M	IME, terminated exam • Bill for exam ended prior to completion. • Requires file review, partial exam and report (including reasons for early termination of exam).	$ 351.59
1131M	IME, out-of-state exam	by report
1132M	Document handling, per page (payable only once per IME referral) Charges must be based only on the following documents in the Claim and Account Center unless the authorizing letter requests a review of ALL documents: • Report of Accident • Re-open application • Medical Provider • Voc Rehab Provider • History	$ 0.07 per printed page
1133M	IME, CAC document processing fee (payable only once per IME referral)	$ 58.82
Modifier -7N	X-rays and laboratory services in conjunction with an IME. • When X-rays, laboratory and other diagnostic tests are provided with an exam, identify the service(s) by adding the modifier – 7N to the usual procedure number. Procedure codes are listed in the L&I Fee Schedules, Radiology and Laboratory Sections.	N/A

Billing State Fund (L&I) for In-State IMEs

For IMEs performed in Washington State, examiners need 1 IME provider account number for each payee they wish to designate.

An IME examiner not working through any IME firms will need just 1 IME number, which will also serve as their payee number.

HOW IME FIRMS MUST BILL FOR IMES CONDUCTED IN WASHINGTON STATE

The chart below shows which provider account number and/or National Provider Identifier (NPI) to use in 24J of the CMS 1500 form based on the IME service provided. The NPI must be registered with the department.

Use only the IME examiner's provider account number/NPI for these codes:		Use only the IME firm provider account number/NPI for these codes:	The following codes may be billed by the IME examiner, the IME firm, or by the performing provider. Only 1 provider may bill these codes:
1028M	1118M	1100M	1124M
1038M	1120M	1101M	CPT® Code 90801
1048M	1123M		CPT® Codes 96101, 96102
1066M	1125M		CPT® Codes 96118, 96119
1104M 1105M	1128M		X-ray, diagnostic laboratory tests in conjunction with IME (Use modifier -7N.)
1108M	1129M		1045M
1109M	1130M		
1111M 1112M	CPT® Codes 99441-99443		

NOTE: On CMS-1500, IME firms may use their own provider account number (box 33b) and/or NPI (box 33a) as the "payee" although it is not required if the same provider account number /NPI is in box 24J.

Billing for Out-of-State IMEs

- A separate provider account number is required for IMEs conducted outside of Washington State.
- IME examiners must meet L&I's criteria for approved examiners.
- IME examiners must be approved by L&I. To obtain the procedures and an IME provider application, go to http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/IME/BecomeIMEProv/default.asp When you submit your application include a copy of the doctor's license for the state where the exam will be conducted and a current curriculum vitae (CV).
- Firms will not be required to put the examiner provider account number on State Fund bills.
- Bills for out-of-state IMEs must contain the IME firm's provider account number in box 33b of the CMS-1500 bill form.
- Bill your usual and customary fees.
- Use billing code 1131M for all services, **except** 1100M and 1101M, and the CPT® codes for neuropsychological evaluation and testing. Combine all 1131M charges into one line-item on your bill. Also use 1131M for activities occurring after the IME, such as addendums.
- L&I and self insurers will reimburse 1131M by report.

Standard and Complex Coding

The exam should be sufficient to achieve the purpose and reason the exam was requested. Choose the code based on the number of body areas or organ systems that need to be examined to fully evaluate the accepted condition(s) or the condition(s) contended as work related. Be sure the report documents the relationship of the areas examined to the accepted or contended conditions.

The definitions of body areas and organ systems from the Current Procedural Terminology (CPT®) book must be used to distinguish between standard and complex IMEs.

The following **body areas** are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttock
- Back
- Each extremity

The following **organ systems** are recognized:

- Eyes
- Ears, Nose, Mouth and Throat
- Cardiovascular
- Gastrointestinal
- Respiratory
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic

NOTE: Each extremity is counted once per extremity examined, when determining standard or complex codes. For example, in a case of bilateral carpal tunnel syndrome, if both right and left extremities are examined, 2 body areas would be counted.

NATUROPATHIC PHYSICIANS

Naturopathic physicians must use the E/M CPT® codes to bill office visit services, CPT® codes 99361-99373 to bill case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

USE OF CPT® E/M CODES FOR NATUROPATHIC OFFICE VISITS

Naturopathic physicians may bill the first 4 levels of CPT® new and established patient office visit codes. L&I uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last 3 years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

Refer to Case Management Services, page **36** in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

L&I **will not pay** naturopathic physicians for services that are not specifically allowed. Refer to Chapter 296-23 WAC for additional information.

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT® codes								
80048	80069	82247	82374	82550	82977	84100	84295	84478
80051	80076	82248	82435	82565	83615	84132	84450	84520
80053	82040	82310	82465	82947	84075	84155	84460	84550

Calculating Payment for Automated Tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Calculate the payment according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- The total number of remaining unduplicated automated tests is counted.

See the following table to determine the payable fee based on the total number of unduplicated automated tests performed.

Number of Tests		Fee
1	Test	Lower of the single test or $10.19
2	Tests	$10.19
3 –12	Tests	$12.50
13 –16	Tests	$16.69

Number of Tests		Fee
17 – 18	Tests	$18.70
19	Tests	$21.63
20	Tests	$22.33
21	Tests	$23.03
22 –23	Tests	$23.73

Calculating Payment for Panels with Automated and NonAutomated Tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual nonautomated test(s).

For example CPT® code 80061 is comprised of 2 automated multichannel tests and 1 non-automated test. As shown below, the fee for 80061 is **$26.21.**

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $ 10.19
Nonautomated: CPT® 83718		Nonautomated: $ 16.02
	Maximum Payment:	$ 26.21

Calculating Payment for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how to calculate the maximum payment when panel codes 80050, 80061 and 80076 are billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040(1) 82247(1) 82248 84075(1) 84155(1) 84450(1) 84460(1)	82977 83615	19 Unduplicated Automated Tests	$ 21.63
	84443					$32.75
	85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009					$15.20
		83718				$16.02
				84439		$17.11
Nonautomated Tests				85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 (1)		$ 0.00
					MAXIMUM PAYMENT:	$ 81.08

(1) Duplicated tests

REPEAT TESTS

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters.

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) do not qualify as separate encounters.

The medical necessity for repeating the test(s) must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests section.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed as follows:

- The fee is payable only to the provider who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee **is not allowed** when the cost of collecting the specimen(s) is minimal, such as:
  - A throat culture,
  - Pap smear or
  - A routine capillary puncture for clotting or bleeding time.
- Specimen collection performed by patients in their homes **is not paid** (such as stool sample collection).

Use CPT® code 36415 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

Travel will **not be paid** to nursing home or skilled nursing facility staff that performs specimen collection.

Travel **will be paid** in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- The provider personally draws the specimen, and
- The trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Use HCPCS code P9603 to bill for actual mileage (1 unit equals 1 mile). HCPCS code P9604 is **not covered**.

Handling and conveyance will **not be paid**, (for example, shipping or messenger or courier service of specimen(s)). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are considered to be integral to the process and are bundled into the total fee for testing service.

STAT LAB FEES

Usual laboratory services **are covered** under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to 1 STAT charge per episode (not once per test).

Tests ordered STAT should be limited to only those needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code
80047
80048
80051
80069
80076
80100
80101
80156
80162
80164
80170
80178
80184
80185
80188
80192
80194
80196
80197
80198
81000
81001
81002

CPT® Code
81003
81005
82003
82009
82040
82055
82150
82247
82248
82310
82330
82374
82435
82550
82565
82803
82945
82947
83615
83663
83874
83880
84100

CPT® Code
84132
84155
84157
84295
84302
84450
84484
84512
84520
84550
84702
84704
85004
85007
85025
85027
85032
85046
85049
85378
85380
85384
85396

CPT® Code
85610
85730
86308
86367
86403
86880
86900
86901
86920
86921
86922
86923
86971
87205
87210
87281
87327
87400
89051

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto

TESTING FOR AND TREATMENT OF BLOODBORNE PATHOGENS

The insurer may pay for post-exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease. Authorization of treatment in cases of probable exposure (not injury) does not bind the insurer to allowing a claim at a later date.

The exposed worker must apply for benefits (submit an accident report form) before the insurer can pay for testing and treatment.

Covered Testing Protocols

Testing for Hepatitis B, C and HIV should be done at the time of exposure and at 3, 6, and 12 months post exposure. The following test protocols are **covered**:

Hepatitis B (HBV)

- HbsAg (hepatitis B surface antigen).
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen).
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C (HCV)

- Enzyme Immunoassay (EIA).
- Recombinant Immunoblot Assay (RIBA).
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are **covered** services if HCV is an accepted condition on a claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR).
- Branched-chain DNA (bDNA).
- Genotyping.
- Liver biopsy.

HIV

There are 2 blood tests needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, and
- A Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test.
- EIA test.
- Western Blot test.
- Immunofluorescent antibody.

The following tests are **covered** services if HIV is an accepted condition on a claim:

- HIV antiretroviral drug resistance testing.
- Blood count, kidney, and liver function tests.
- CD4 count.
- Viral load testing.

Post-exposure Prophylaxis for HBV

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate.

Post-exposure Prophylaxis for HIV

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization is not required**.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count and
- Renal and hepatic chemical function tests

Covered Bloodborne Pathogen Treatment Regimens

Chronic hepatitis B (HBV)

- Interferon alfa-2b.
- Lamivudine.

Hepatitis C (HCV) – acute

- Mono therapy.
- Combination therapy.

HIV/AIDS: Covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS). These guidelines are available on the web at http://aidsinfo.nih.gov/ .

Treating a Reaction to Testing or Treatment of an Exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to **covered** treatment for a probable exposure.

BLOODBORNE PATHOGEN BILLING CODES

Diagnostic Test/Procedure

CPT® Code
47100
83890
83894
83896
83898
83902
83912
86689
86701
86704
86706

CPT® Code
86803
86804
87340
87390
87521
87522
87901
87903
87904

Treatment Related Procedures

CPT® Code
78725
86360
87536
80076
90371
90746 (adult)
90772-90779

CPT® Code
99201-99215
99217-99220

PHARMACY SERVICES

PHARMACY FEE SCHEDULE

Payment for drugs and medications, including all oral nonlegend drugs, will be based on the pricing methods described below. Refer to WAC 296-20-01002 for definition of Average Wholesale Price (AWP).

Drug Type	Payment Method
Generic and single or multisource Brand	AWP less 10% (+) $ 4.50 professional fee
Brand with generic equivalent (substitution allowed)	AWP less 10% (+) $ 3.00 professional fee
Compounded prescriptions	Allowed cost of ingredients (+) $4.50 professional fee (+) $4.00 compounding time fee (per 15 minutes)

Orders for over-the-counter nonoral drugs or nondrug items must be written on standard prescription forms. Price these on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable (RCW 82.08.0281).

COVERAGE POLICY

The outpatient formulary can be found in Appendix F, page **211** at the end of this document or at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp

Preferred Drug List

L&I uses a subset of the Washington State Preferred Drug List (PDL). A current list of the drug classes that are part of the workers' compensation benefit and on the PDL is available at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/Presc/PDL.asp.

Endorsing the Preferred Drug List

Providers may endorse the PDL by:

- Registering online at http://www.rx.wa.gov/tip.html or
- Filling out and returning a registration form available
  - at http://www.rx.wa.gov/tip.html or
  - by calling Benefit Control Methods at 866-381-7879 or 866-381-7880

Endorsing Practitioner and Therapeutic Interchange Program

Endorsing practitioners may indicate Dispense as Written (DAW) on a prescription for a nonpreferred drug on the PDL and the prescription will be filled as written.

Alternatively, if an endorsing practitioner indicates substitution permitted on a prescription for a nonpreferred drug on the PDL, the pharmacist will interchange a preferred drug for the nonpreferred drug and a notification will be sent to the prescriber.

Therapeutic interchange **will not** occur when the prescription is a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug as exempted by law. See WAC 296-20-01002 for definitions relating to the Therapeutic Interchange Program:

- Endorsing practitioner
- Refill
- Therapeutic alternative
- Therapeutic interchange

Due to federal regulations, therapeutic interchange will not take place when the prescription is for a schedule II nonpreferred drug. However, L&I will honor the prescription if an endorsing practitioner indicates DAW for a schedule II nonpreferred drug.

Exception: Fentanyl patch (Duragesic) **will not** be routinely covered. For exception criteria see http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/CovMedDev/SpecCovDec/duragesic.asp

OBTAINING AUTHORIZATION FOR NONPREFERRED DRUGS

The table lists what providers should do to obtain authorization for **nonpreferred** drugs.

Outpatient drug formulary	Endorsing provider	Nonendorsing provider
Preferred Drug List	Write DAW for nonpreferred drugs	Contact the PDL Hotline (888) 443-6798
Remainder of drug classes	Contact the PDL Hotline (888) 443-6798	Contact the PDL Hotline (888) 443-6798

The PDL Hotline is open Monday through Friday 8:00 am to 5:00 pm PST.

Filling prescriptions after hours

If a pharmacy receives a prescription for a nonpreferred drug when authorization cannot be obtained, the pharmacist may dispense an emergency supply of the drug by entering a value of 6 in the DAW field. L&I **must authorize** additional coverage for the nonpreferred drug.

NOTE: An emergency supply is typically 72 hours for most drugs or up to 10 days for most antibiotics, depending on the pharmacist's judgment.

Retaining prescriptions

WAC 296-20-02005 (Keeping of records) requires that records must be maintained for audit purposes for a minimum of 5 years.

NCPDP V5.1 PAYER SHEET

L&I uses version 5.1 of the NCPDP payer sheet to process prescriptions for payment in the point of service (POS) system. The current version is available online at http://www.LNI.wa.gov/ClaimsIns/Files/Providers/PayerSheet.pdf

INITIAL PRESCRIPTION DRUGS OR "FIRST FILLS"

L&I **will** pay pharmacies or reimburse workers for prescription drugs prescribed during the initial visit for State Fund claims regardless of claim acceptance. Refer to WAC 296-20-01002 for definitions of initial prescription drug and initial visit.

L&I **will not** pay:

- For refills of the initial prescription before the claim is accepted,
- For new prescription written after the initial visit but before the claim is accepted or
- If it is a federal or self-insured claim.
    - Pharmacies should bill the appropriate federal or self-insured employer.

If a payment is made by L&I on a claim that has been mistakenly filed as a State Fund claim, payment will be recovered.

Payment for "first fills" shall be based on L&I's fee schedule including but not limited to screening for drug utilization review (DUR) criteria, preferred drug list (PDL) provisions, 30-day supply limit and formulary status. Your bill must be received by L&I within 1 year of the date of service. For additional information and billing instructions, go to http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/Presc/Billing/FirstFills.asp or see the Pharmacy Prescription Billing Instructions manual.

THIRD PARTY BILLING FOR PHARMACY SERVICES

Pharmacy services billed through a third party pharmacy biller **will be paid** using the pharmacy fee schedule **only when**:

- A valid L&I claim exists; and
- The dispensing pharmacy has a signed Third Party Pharmacy Supplemental Provider Agreement on file at L&I; and
- All POS edits have been resolved during the dispensing episode by the dispensing pharmacy.

L&I pharmacy providers that bill through a third party pharmacy billing service must:

- Sign a Third Party Pharmacy Supplemental Provider Agreement
- Allow third party pharmacy billers to route bills on their behalf,
- Agree to follow L&I rules, regulations and policies and
- Ensure that third party pharmacy billers use L&I's online POS system and
- Review and resolve all online POS system edits using a **licensed pharmacist** during the dispensing episode.

Third party pharmacy billers **cannot resolve** POS edits. Third Party Pharmacy Supplemental Agreements can be obtained either through the third party pharmacy biller or by contacting Provider Accounts at (360) 902-5140. The third party pharmacy biller and the pharmacy complete the agreement together and return it to L&I. For more information refer to the Pharmacy Services website at http://www.LNI.wa.gov/ClaimsIns/Providers/Treatment/Presc/default.asp.

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The insurer covers emergency contraceptive pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

These services require **prior authorization** by the insurer. The insurer will only pay home health agencies and/or independent registered nurses for infusion therapy services and/or therapeutic, diagnostic, vascular injections.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. **Prior authorization is required** for supplies (including infusion pumps) and must be billed with HCPCS codes. See WAC 296-20-1102 for information on the rental or purchase of infusion pumps. Implantable infusion pumps are **not routinely covered**.

> **Exception:** When a spinal cord injury is the accepted condition the insurer may pay for an implantable pump for Baclofen. See WAC 296-20-03014(6).

Drugs

Infusion therapy drugs, including injectable drugs, are **payable only to pharmacies**. Drugs must be authorized and billed with NDC codes or UPC codes if NDC codes are not available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers must bill their "usual and customary" charge for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax and fitting fees are **not payable separately**. Include these charges in the total charge for the supply. See WAC 296-20-1102 for information on the rental or purchase of DME.

PURCHASING OR RENTING DME

Required Modifers –NU or –RR

A modifier is always required on all HCPCS codes that are used to purchase or rent DME.

–NU for a new purchase or

–RR for a rental.

The HCPCS Section of the Professional Services Fee Schedule lists the HCPCS E codes and the HCPCS K codes that require either –NU or –RR. Look in the HCPCS/CPT® code column of the fee schedule for the appropriate modifier.

DME codes fall into one of 3 groups relative to modifier usage. DME that is:

- Only purchased by L&I (only –NU modifier allowed).
- Only rented by L&I (only –RR modifier allowed).
- Either purchased or rented by L&I (either –NU or –RR modifier allowed).

Bills submitted without the correct modifier will be denied payment. Providers may continue to use other modifiers, for example –LT,–RT etc in conjunction with the mandatory modifiers if appropriate (up to 4 modifiers may be used on any 1 HCPCS code).

Exception: HCPCS code E1340 (Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes) does not require a modifier.

L&I **will not** purchase used equipment.

Self-insured employers **may purchase** used equipment.

DME Purchase

Purchased DME must have the –NU modifier. The new purchase codes and their modifier can be found in the HCPCS Section of the Professional Services Fee Schedule. Purchased DME belongs to the worker.

DME Rental

DME that is rented must have the –RR modifier. The rental codes and their modifier can be found in the HCPCS Section of the Professional Services Fee Schedule.

Rental payments will not exceed 12 months. At the 12th month of rental, the equipment is owned by the worker. The insurer may review rental payments at 6 months and decide to purchase the equipment at that time. The purchased DME belongs to the worker.

The maximum allowable rental fee is based on a per month period. Rental of 1 month or less is equal to 1 unit of service.

Exception: HCPCS E0935 and E0936, continuous passive motion exercise device for use on knee only and continuous passive motion exercise device for use other than knee respectively are rented on a per diem basis with one unit of service equaling one day.

If the equipment is being rented for 1 day, use the same date for the first and last dates of service. If the equipment is being rented for more than 1 day, use the actual first and last dates of service. Errors will result in suspension and/or denial of payment of the bill and any subsequent bills.

Some equipment will only be rented by the insurer.

- These normally are extremely high cost items or items that are only used for short duration.
- Examples of these items include: E0118, E0193, E0194, E0277, E0935, E0936, E1800-E1818, E1825, E1830 and E1840.

Note: This is not a complete list.

During the authorized rental period, the DME belongs to the provider. When the equipment is no longer authorized, the DME will be returned to the provider. If the unauthorized DME is not returned to the provider within 30 days, the provider can bill the worker for charges related to DME rental, purchase and supplies that accrue after DME authorization is denied by the insurer.

DME Purchase After Rental

Equipment rented for less than 12 months and permanently required by the worker:

- The provider will retrieve the rental equipment and replace it with the new DME item.
- The provider should bill the usual and customary charge for the new replacement DME item. The HCPCS code billed will require a –NU modifier.
- L&I will pay the provider the new purchase price for the replacement DME item in accordance with the established maximum fee.
- Self-insurers may purchase the equipment and receive rental credit toward the purchase.

DME, Miscellaneous, E1399

HCPCS code E1399 will be paid by report.

- E1399 is payable only for DME that does not have a valid HCPCS code assigned.
- All bills for E1399 items must have either the –NU or –RR modifier.
- A description must be on the paper bill or in the remarks section of the electronic bill.
- The item must be appropriate relative to the injury or type of treatment being received by the worker.

OXYGEN AND OXYGEN EQUIPMENT

L&I primarily rents oxygen equipment and will no longer rent to purchase.

Types of Oxygen Systems

Stationary systems: Stationary oxygen systems include gaseous oxygen cylinders, liquid oxygen systems and oxygen concentrators.

- Oxygen gas cylinders contain oxygen gas stored under pressure in tanks or cylinders. Large H cylinders weigh approximately 200 pounds and provide continuous oxygen at 2 liters per minute for 2.5 days.
- Liquid oxygen systems store oxygen in a reservoir as a very cold liquid that converts to gas when released from the tank. Liquid oxygen is more expensive than compressed gas but takes up less space and can be more easily transferred to a portable tank. A typical liquid oxygen system weighs approximately 120 pounds and provides continuous oxygen at 2 liters per minute for 8.9 days. Certain liquid oxygen systems can provide oxygen at the same rate for 30 days or more.
- Oxygen concentrators are electric devices that extract oxygen from ambient air and deliver oxygen at 85% or greater at concentration of up to 4 liters per minute. A back-up oxygen cylinder is used in the event of a power failure for patients on continuous oxygen using concentrators.

Portable systems: Portable oxygen systems may be appropriate for patients with stationary oxygen systems who are ambulatory within the home and occasionally go beyond the limits of the stationary system tubing. Some portable oxygen systems, while lighter in weight than stationary systems, are not designed for patients to carry.

- Small gas cylinders, such as the E cylinder, are available as portable systems. The E cylinder weighs 12.5 pounds alone, 22 pounds with a rolling cart.
- Portable systems sometimes referred to as ambulatory systems are lightweight (less than 10 pounds) and can be carried by most patients. Small gas cylinders are available that weigh 4.5 pounds.
- Portable liquid oxygen systems that can be filled from the liquid oxygen reservoir are available in various weights. The smallest weighs 3.4 pounds with a conserver and provides oxygen at 2 liters per minute for 10 hours.

Oxygen System Fees

Stationary: Fee schedule payments for stationary oxygen system rentals are all-inclusive. One monthly fee is paid for a stationary oxygen system. This fee includes payment for the equipment, contents (if applicable), necessary maintenance and accessories furnished during a rental month.

If the worker owns a stationary oxygen system, payment will be made for contents of the stationary gaseous (E0441) or liquid (E0442) system.

Portable: Fee schedule payments for portable oxygen system rentals are all-inclusive. One monthly fee is paid for a portable oxygen system. This fee includes payment for the equipment, contents, necessary maintenance and accessories furnished during a rental month.

If the worker owns a portable oxygen system, payment may be made for the portable contents of the gaseous (E0443) or liquid (E0444) portable system.

The fee for oxygen contents (stationary or portable) is billed once a month, not daily or weekly. It equals 1 unit of service.

Oxygen Concentrators

Fee schedule payments for oxygen concentrators are all-inclusive. One monthly fee is paid for an oxygen concentrator. This fee includes payment for the equipment rental, necessary maintenance and accessories furnished during a rental month.

Oxygen Accessories

Accessories include but are not limited to:

- Cannulas (A4615)
- Humidifiers (E0555)
- Masks (A4620, A7525)
- Mouthpieces (A4617)
- Nebulizer for humidification (E0580)
- Oxygen conserving devices (A9900)
- Regulators (E1353)
- Stand/rack (E1355)
- Transtracheal catheters (A4608)
- Tubing (A4616)

These are included in the payment for rented systems. The supplier must provide any accessory ordered by the physician. Accessories are separately payable only when they are used with a patient owned system.

REPAIRS AND NONROUTINE SERVICE

Rented Equipment Repair

Repair, nonroutine service and maintenance are included as part of the monthly rental fee on DME. No additional payment will be provided. This excludes disposable and nonreusable supplies.

Purchased Equipment Repair

Repair, nonroutine service and maintenance on purchased equipment that is out of warranty will be paid by report.

In those cases where damage to a piece of DME is due to worker:

- Abuse,
- Neglect or
- Misuse

The repair or replacement is the responsibility of the worker. Replacement of lost or stolen DME is also the responsibility of the worker.

E1340 should be billed per each 15 minutes. Each 15 minutes should be represented by one unit of service in the 'Units' field.

> **For example**, 45 minutes for a repair or nonroutine service of equipment requiring a skilled technician would be billed with 3 units of service.

WARRANTIES

A copy of the original warranty is required on each repair service completed. For State Fund claims, send a copy to:

> Department of Labor and Industries
>
> PO Box 44291
>
> Olympia, WA 98504-4291

Write the claim number in the upper right-hand corner of the warranty document.

Payment will be denied if no warranty is received or if the item is still under warranty.

DME Item Type	Required Warranty Coverage
DME purchased new, excluding disposable and nonreusable supplies	Limited to the manufacturer's warranty
Rented DME	Complete repair and maintenance coverage is provided as part of the monthly rental fee
E1230 Power operated vehicle (3- or 4-wheel nonhighway) "Scooter"	Minimum of 1 year or manufacturer's warranty whichever is greater
Wheelchair frames (purchased new) and wheelchair parts	Minimum of 1 year of manufacturer's warranty whichever is greater
HCPCS codes K0004, K0005 and E1161	Lifetime warranty on side frames and cross braces

L&I pays for TENS units, services and supplies under contract only. Refer to the TENS section, page 72 , for more information.

For further information on miscellaneous services and appliances, see WAC 296-23-165.

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT® code 97010) is bundled for all providers.

Hot or cold therapy durable medical equipment (DME) **is not covered**.

> **Exception**: HCPCS code E0230, Ice cap or collar, is **covered** for DME providers only.
>
> WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or **not covered**.

AUTHORIZATION REQUIREMENTS

If DME requires **prior authorization** and it is not obtained then bills may be denied.

Prior authorization for State Fund claims can be obtained by calling:

- Claim manager or
- Provider Hotline 1-800-848-0811 or from Olympia 360-902-6500.

Contact the self-insured employer for prior authorization on self-insured claims.

DENTAL SERVICES

Dental providers licensed in the state in which they practice may be paid for performing dental services (WAC 296-20-110 and WAC 296-23-160).

This policy pertains to bills submitted for dental services.

PRE-EXISTING CONDITIONS

Pre-existing conditions are not payable unless medically justified as related to the injury. Preauthorization is required for treatment.

Any dental work needed due to underlying conditions unrelated to the industrial injury is the responsibility of the worker (WAC 296-20-110). It is the responsibility of the dentist to advise the worker accordingly. Please advise the worker if there are underlying conditions that will not be covered.

Periodontal disease is an underlying condition that is not covered because it is not related to industrial injuries.

To avoid delays in treatment, please exclude information regarding treatment that is not directly related to the injury.

WHO CAN BILL

Dental providers including:

- Dentists
- Oral and Maxillofacial surgeons
- Orthodontists
- Denturists
- Hospitals
- Dental clinics

BILLING RULES

Provider Number

You must have an L&I provider account number to be paid for services provided to injured workers (WAC 296-20-015). You can find more information about becoming an L&I provider at http://www.lni.wa.gov/ClaimsIns/Providers/Become/default.asp

For self-insured workers' compensation claims contact the insurer directly for provider account number requirements. For assistance in locating self-insurers go to: http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

BILLING INSTRUCTIONS

Billing Forms

To submit a billing for State Fund claims, dentists should use L&I's Statement for Miscellaneous Services form. To submit a billing for Crime Victims Compensation (CVC) claims, dentists should use CVC's Statement for Crime Victims Miscellaneous Services. Forms can be found at http://www.lni.wa.gov/FormPub/BySubject.asp.

Failure to use L&I's most recent billing form may delay payment.

Complete the billing form itemizing the service rendered, including the code, materials used and the injured tooth number(s). When using Current Dental Terminology (CDT) codes, please include the "**D**" in front of the code billed to avoid delays in claim/bill processing.

Bills must be submitted within one year from the date the service is rendered (WAC 296-20-125).

AUTHORIZATION AND TREATMENT PLAN REQUIREMENTS

Procedures requiring prior authorization are noted in the attached fee schedule by a Y in the "Prior Auth" column.

Contact the following for procedures requiring prior authorization:

- L&I claim manager for state workers' compensation claims and CVC claims
- Self-insured company's insurer for self-insured workers' compensation claims.

Only claim managers can authorize dental services for state workers' compensation claims and CVC claims.

For self-insured workers' compensation claims, contact the insurer directly for prior authorization procedure details.

http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

To obtain authorization for a treatment plan the following are required:

- Causal relationship of injury to condition of the mouth and teeth.
- Extent of injury.
- Alternate treatment plan.
- Time frame for completion.
- Medical history and risk level for success.

Please include:

- Procedure code.
- Tooth number.
- Tooth surface.
- Charge amount.

Do not use a billing form to submit your treatment plan.

TREATMENT PLAN SUBMISSION

Claim services requiring prior authorization require a treatment plan. The dentist should outline the extent of the dental injury and the treatment plan (WAC 296-20-110).

The treatment plan and/or alternative treatment plan must be completed and submitted before authorization can be granted. If other providers are performing services, it will also be necessary for them to submit treatment plans. A 6-point per tooth periodontal chart and/or X-rays may be requested.

PRIOR AUTHORIZATION REVIEW

The claim manager will review the treatment plan and the relation to the industrial injury and make a final determination for all services relating to restorative, endodontic, prosthodontic, prosthetic, implant, orthodontics, surgery and anesthesia procedures.

In cases presenting complication, controversy or diagnostic/therapeutic problems, consultation by another dentist may be requested by the claim manager to support authorization for procedures.

To avoid delays in authorization of treatment, include the following in your plan:

- Worker's full name,
- Claim number,
- Provider name, address and telephone number

State the condition of the mouth and involved teeth including:

- Missing teeth, existing caries and restorations.
- Condition of involved teeth prior to the injury (caries, periodontal status).

Mail State Fund **treatment plans** to:

Department of Labor & Industries

PO Box 44291

Olympia, Washington 98504-4291

Mail CVC claim **treatment plans** to:

Department of Labor & Industries

PO Box 44520

Olympia, Washington 98504-4520

State Fund treatment plans (**not billing** info) may be faxed to:

(360) 902-4292

(360) 902-4565

(360) 902-4566

(360) 902-4567

(360) 902-5230

(360) 902-6100

(360) 902-6252

(360) 902-6460

SELF-INSURERS TREATMENT PLAN PROCEDURES

For self-insured claims, contact the self-insurer directly for treatment plan submission procedures.

http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

DOCUMENTATION AND RECORDKEEPING REQUIREMENTS

Chart Notes

You must submit legible chart notes and reports for all of your services. This documentation must verify the level, type and extent of service (WAC 296-20-010). Legible copies of office notes are required for all initial and follow-up visits (WAC 296-20-06101). You can find documentation and record keeping requirements in the General Provider Billing Manual, F248-100-000. The billing manual is available by request at **1-800-848-0811**.

Acceptance of a Claim

If you diagnose a worker for an occupational injury or disease associated with a dental condition, you are responsible for reporting this to the insurer. You initiate the State Fund claim or CVC claim for your patient when you send an accident report to L&I.

The State Fund Report of Industrial Injury or Occupational Disease (Accident Report) (ROA) form can be ordered at:

http://lni.wa.gov/FormPub/Detail.asp?DocID=1599 or call 1-800-LISTENS or 1-360-902-4300.

Self-insurers have accident report forms at their locations.

Attending Provider

If dental treatment is the only treatment the injured worker requires and you are directing the care, you will be the attending provider (AP).

Your responsibility as the AP includes:

- Documenting employment issues in the injured worker's chart notes, including:
    - A record of the worker's physical and medical ability to work, and
- Information regarding any rehabilitation that the worker may need to undergo.
- Restrictions to recovery,
- Any temporary or permanent physical limitations, and
- Any unrelated condition(s) that may delay recovery must also be documented.

For ongoing treatment, use the standard **SOAP** (Subjective, Objective, Assessment, Plan and progress) format. Information on the format can be found in the Charting Format section, page of this document.

L&I'S REVIEW OF DENTAL SERVICES

L&I or its designee may perform periodic independent evaluations of dental services provided to workers. Evaluations may include, but are not limited to, review of the injured worker's dental records.

HOME HEALTH SERVICES

Home nursing services includes attendant care, home health, home infusion and hospice. All of these services require **prior authorization**. The insurer will only pay for services specifically authorized. Services and supplies must be proper and necessary because of physical restrictions caused by the industrial injury or disease.

ATTENDANT CARE SERVICES

Attendant care services provide assistance in the home for personal care and activities of daily living. Attendant care services must be provided by an agency that is licensed, certified or registered to provide home health or home care services. Attendant care agencies must have RN supervision of care givers providing care to a worker. In addition to prior authorization attendant care agencies must obtain a provider account number and bill with the appropriate code(s) in order to be reimbursed for services. RN supervision services are not paid separately and are included in the hourly fee as business overhead. Attendants for workers may be:

- Registered aides
- Certified nurse's aides
- Licensed practical nurses
- Registered nurses

The agency providing services must be able to provide the type of attendant and supervision necessary to address the workers medical and safety needs.

All RN evaluation reports must be submitted to L&I within 15 days of the initial evaluation and then annually or when the worker's condition changes and necessitates a new evaluation. The insurer will notify the provider in writing if current approved hours are modified or changed. Refer to WAC 296-20-091 and WAC 296-23-246 for additional information.

L&I will determine the maximum hours and type of authorized attendant care based on the nursing assessment of the worker's personal care needs that are proper and necessary and related to the worker's industrial injury. Self-insurers may use other methods to determine care needs. Personal care may include but is not limited to:

- Administration of medication
- Bathing
- Personal hygiene and skin care
- Bowel and bladder incontinence
- Feeding assistance
- Mobility assistance
- Turning and positioning,
- Transfers or walking
- Supervision due to cognitive impairment, behavior or blindness.
- Range of motion exercises
- Ostomy care

Attendant Service Codes

Code	Description	Fee
S9122	Attendant in the home provided by a certified or registered aide per hour	$26.01
S9123	Attendant in the home provided by a registered nurse per hour	$56.57
S9124	Attendant in the home provided by licensed practical nurse per hour	$41.29

Bundled Codes and DME

Attendant care agencies may bill for wound care and medical treatment supplies. Covered HCPCS codes which are listed as bundled in the fee schedule are separately payable to home attendant care service providers for supplies used in the worker's home.

Attendant care agencies may bill HCPCS code S8301 for infection control supplies when caregivers are providing care to a worker with an infectious wound. Prior authorization and prescription from the treating physician is required. An invoice for the supplies must be submitted with the bill.

Noncovered Services

Social work and chore services are **not covered**, except as part of home hospice care.

Chore services and other services that are only needed to meet the worker's environmental needs are **not covered**. The following services are examples of chore services.

- Childcare
- Laundry and other housekeeping activities
- Meal planning and preparation
- Other everyday environmental needs unrelated to the medical care of the worker
- Recreational activities
- Shopping and errands for the worker
- Transportation of the worker
- Yard work
- Work associated activities

Workers must not be left unattended during approved service hours. Attendant care providers may not bill for services the attendant performs in the home while the worker is away from the home. Attendant care services will not be covered when a worker is in the hospital or a nursing facility unless the worker's industrial injury causes a special need that the hospital or nursing facility cannot provide and is specifically authorized. The agency can bill workers for hours not approved by L&I if the worker is notified in advance they are responsible for payment.

Spouse Attendant Care

Spouses who are not employed by an agency, who provided L&I approved attendant services to their spouse prior to October 1, 2001 and who met criteria in the year 2002 may continue to bill for spouse attendant care. Spouses are limited to 70 hours per week. Exemptions from this limit will be made based on L&I review. L&I will determine the maximum hours of approved attendant care based on an independent nurse evaluation which will be performed yearly. If the worker requires more than 70 hours per week of attendant care L&I can approve a qualified agency to provide the additional hours of care. L&I will determine the maximum amount of additional care based on an RN evaluation.

Spouse Attendant Code

Code	Description	Fee
8901H	Spouse attendant in the home per hour	$12.78

Travel

Workers who qualify for attendant care and are planning a long distance trip, must inform L&I of the plans and request specific authorization for coverage during the trip. L&I will not cover travel expenses of the attendant or additional care hours. The worker must coordinate the trip with the appropriate attendant care agencies.

Temporary Or Respite Attendant Care

L&I can approve short term agency attendant care services for workers who qualify for attendant care and who have a spouse attendant or a non-paid care giver who is temporarily unable to provide the worker's care. L&I will determine the maximum hours of authorized care and type of care based on the RN evaluation. Temporary or respite care requires prior authorization. The agency providing the care must meet the criteria for L&I approval as a provider. If a qualified attendant care agency cannot be found to provide care in the home, the worker can be approved to stay in a residential care facility.

The insurer will notify the provider in writing if current approved hours are modified or changed.

Nursing Evaluations

Independent nursing evaluation, when requested by the insurer, may be billed under Nurse Case Manager or Home Health Agency RN codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. The following code applies to in-home hospice care:

Code	Description	Fee
Q5001	Hospice care, in the home, per diem	By report

For hospice services performed in a facility, please refer to Nursing Home, Residential and Hospice Care Services in the Facility Section.

HOME HEALTH SERVICES

L&I will pay for aide, RN, physical therapy, occupational therapy and speech therapy services provided by a licensed home health agency when services become proper and necessary to treat a worker's accepted condition. Home health services require prior authorization. Home health services are for intermittent or short term treatment or therapy for a medial condition. Home health services must be requested by a physician. Services require an initial evaluation by the RN or therapist and a written report must be submitted to L&I within 15 days of the evaluation.

Payment for continued treatment will require documentation of the worker's needs and progress and renewed authorization at the end of an approved treatment period. The worker is expected to be present and ready for the home health nurse or therapist and non-cooperation can result in termination of services. Home health services maybe terminated or denied when the worker's medical condition and situation allows for outpatient treatment.

Documentation

Home nursing care providers must submit the initial assessment, attending provider's treatment plan and /or orders and home care treatment plan within 15 days of beginning the service. Updated plans must be submitted every 30 days thereafter.

Home Health Codes

Code	Description	Fee
G0151	Services of Physical Therapist in the home. 15 min. units. Maximum of 4 units per day.	$37.32
G0152	Services of Occupational Therapist in the home. 15 min units. Maximum of 4 units per day.	$38.69
G0153	Services of Speech Therapist in the home. 15 min units. Maximum of 4 units per day.	$38.69
G0154	Services of skilled nurse RN/LPN in the home 15 min unit.	$38.69
G0156	Services of home health aide in the home 15 min unit. Maximum of 8 units per day	$6.50

Bundled Codes And DME

Home health and home infusion services may bill appropriate HCPCS codes for wound care and medical treatment supplies. Covered HCPCS codes listed as bundled in the fee schedule are separately payable to home health and home care providers for supplies used during the home health visit. See WAC 296-20-01002 for the definition of bundled services. Durable medical equipment may require specific authorization prior to purchase.

HOME INFUSION SERVICES

Home infusion services provide drug administration, parenteral hydration, and parenteral feeding to a worker in the home. Skilled nurses contracted by the home infusion service provide education of the worker and family, evaluation and management of the infusion therapy, and care for the infusion site. Home infusion skilled nurse services will only be authorized when infusion therapy is approved as treatment for the worker's allowed industrial condition. Prior authorization is required for home infusion nurse services, drugs and any supplies regardless of who is providing services Home Infusion services can be authorized independently or in conjunction with home health services.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with National Drug Code (NDC) codes or Universal Product Code (UPC) codes if no NDC codes are available.

The rental or purchase of infusion pumps must be billed with the appropriate HCPCS codes.

See WAC 296-20-1102 for additional information.

> **NOTE:** Home health agencies must have prior authorization and use the RN G0154 visit code when administering home injections or nutritional parenteral solutions only.

Medical Supply companies and Home infusion pharmacies may use the appropriate HCPCS code to bill for parenteral solutions, (TPN), or enteral formula nutrition with prior authorization. Home infusion codes may be billed for initial establishment of nutritional therapy for the worker when services have been authorized.

Home Infusion Codes

Code	Description	Fee
99601	Skilled RN visit for infusion therapy in the home. First 2 hours per visit.	$149.32
99602	Skilled RN visit for each additional hour per visit.	$62.79

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of a **covered** condition.

Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services. CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of bundled codes.

NOTE: Bundled codes contain the word bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

NOTE: This policy does not apply to hospital bills. Refer to the Facilities Section for the hospital acquisition cost policy, page **160**

Supply codes without a fee listed **will be paid** at their acquisition cost.

The total acquisition cost should be billed as 1 charge. The acquisition cost equals:

- The wholesale cost plus
- Shipping and handling plus
- Sales tax.

For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be kept in the provider's office files for a minimum of 5 years.

A provider must submit a hard copy of the wholesale invoice to the insurer when an individual supply item costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Supplies used in the course of an office visit are considered bundled and are not payable separately.

Fitting fees are bundled into the office visit or into the cost of any DME and are not payable separately.

Sales tax and shipping and handling charges are not paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but is not required.

CASTING MATERIALS

Bill for casting materials with HCPCS codes Q4001-Q4051. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies must be billed with HCPCS Code E1399:

- Therapeutic exercise putty
- Rubber exercise tubing
- Anti-vibration gloves

Bills coded with E1399 will be reviewed for payment and must meet the following criteria:

- Description of supply on the paper bill or in electronic remarks
- No other valid HCPCS code is available for the supply
- The supply is appropriate for treatment of the injury and/or authorized by the claim manager

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a provider's office and used to treat a temporary obstruction. Payment for the service is not allowed when the procedure is performed on the same day or during the postoperative period of a major surgical procedure that has a follow up period.

For catheterization to obtain specimen(s) for lab tests, see the Pathology and Laboratory Services section, page **95**.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

L&I follows CMS's policy of bundling HCPCS codes A4263, A4300 and A4550 for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings applied during a procedure, office visit or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed. Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound and
- They are medically necessary and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as:

- Telfa
- Adhesive strips for wound closure
- Petroleum gauze

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as adhesive tape, roll gauze, binders and disposable compression material. They do not include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and will not be paid.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs is bundled for all providers.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or **not covered** (see **Appendices B, C and D and the Durable Medical Equipment section**).

AMBULANCE SERVICES

GENERAL INFORMATION

The ambulance services payment policies are primarily based on the current Medicare payment policies for ambulance services modified to meet the needs of Washington State's workers.

VEHICLE AND CREW REQUIREMENTS

To be eligible to be paid for ambulance services for workers, the provider must meet the criteria for vehicles and crews as established in the Washington Administrative Code (WAC) 246-976 "Emergency Medical Services and Trauma Care Systems" and other requirements as established by the Washington State Department of Health for emergency medical services.

Key sections of this WAC are identified below.

1. General
   - WAC 246-976-260 Licenses required
2. Ground Ambulance Vehicle Requirements
   - WAC 246-976-290 Ground ambulance vehicle standards
   - WAC 246-976-300 Ground ambulance and aid vehicles--Equipment
   - WAC 246-976-310 Ground ambulance and aid vehicles--Communications equipment
   - WAC 246-976-390 Verification of trauma care services
3. Air Ambulance Services
   - WAC 246-976-320 Air ambulance services
4. Personnel
   - WAC 246-976-182 Authorized care
   - Washington State Department of Health, Office of Emergency Medical Services Certification Requirements Guidelines

PAYMENT POLICIES FOR AMBULANCE RELATED SERVICES

Emergency Transport

Ambulance services are paid when the injury to the worker is so serious that use of any other method of transportation is contraindicated. Payment is based on the level of service (provided the services were medically necessary), not simply on the vehicle used.

Air ambulance transportation services, either by helicopter or fixed wing aircraft, will be paid only if:

- The worker's medical condition requires immediate and rapid ambulance transportation that could not have been provided by ground ambulance or
- The point of pickup is inaccessible by ground vehicle or
- Great distances or other obstacles are involved in getting the worker to the nearest place of proper treatment.

Proper Facilities

The insurer pays the provider for ambulance services to the nearest place of proper treatment. To be a place of proper treatment, the facility must be generally equipped to provide the needed medical care for the worker. A facility is not considered a place of proper treatment if no bed is available when inpatient medical services are required.

Multiple Patient Transportation

The insurer pays the appropriate base rate for each worker transported by the same ambulance. When multiple workers are transported in the same ambulance, the mileage will be prorated equally among all the workers transported. The provider must use HCPCS Modifier GM (Multiple Patients on 1 Ambulance Trip) for the appropriate mileage billing codes. The provider is responsible for prorating mileage billing codes based on the number of workers transported on the single ambulance trip.

Nonemergency Transport

Nonemergency transportation by ambulance is appropriate if:

- The worker is bed-confined (see bed-confined criteria below), and it is documented that the worker's accepted medical condition is such that other methods of transportation are contraindicated or
- If the worker's accepted medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Bed-confined criteria:

- The worker is unable to get up from bed without assistance and
- The worker is unable to ambulate and
- The worker is unable to sit in a chair or wheelchair.

Nonemergency transportation may be provided on a scheduled (repetitive or nonrepetitive) or unscheduled basis.

- Scheduled, nonemergency transportation may be repetitive, for example, services regularly provided for diagnosis or treatment of the worker's accepted medical condition or nonrepetitive, (for example, single time need)
- Unscheduled services generally pertain to nonemergency transportation for medically necessary services

Workers may not arrange nonemergency ambulance transportation. Only medical providers may arrange for nonemergency ambulance transportation.

The insurer reserves the right to perform a post audit on any nonemergency ambulance transportation billing to ensure medical necessity requirements are met.

Arrival of Multiple Providers

When multiple providers respond to a call for services, only the provider that furnishes the transport of the worker(s) is eligible to be paid for the services provided. No payment is made to the other provider(s).

Mileage

The insurer pays for mileage (ground and/or air) based on loaded miles only, for example., from the pickup of the worker(s) to their arrival at the destination. The destination is defined as the nearest place of proper treatment.

AMBULANCE SERVICES FEE SCHEDULE

HCPCS Code	Description	Fee Schedule
A0425	Ground mileage, per statute mile	$12.81 per mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)	$633.83
A0427	Ambulance service, advanced life support, level 1 (ALS 1-emergency)	$657.87
A0428	Ambulance service, basic life support, nonemergency transport (BLS)	$346.24
A0429	Ambulance service, basic life support, emergency transport (BLS – emergency)	$554.00
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)	$5,652.91
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	$6,572.32
A0433	Advanced Life Support, Level 2 (ALS 2)	$952.18
A0434	Specialty care transport (SCT)	$1,125.31
A0435	Fixed wing air mileage, per statute mile	$31.47 per mile
A0436	Rotary wing air mileage, per statute mile	$73.11 per mile
A0999	Unlisted ambulance service	By report Restrictions: (1) Reviewed to determine if a more appropriate billing code is available; and (2) Reviewed to determine if medically necessary

AUDIOLOGY AND HEARING SERVICES

The following policies and requirements apply to all hearing aid services and devices except for CPT® codes.

SELF-INSURERS

Self-insurers who have entered into contracts for purchasing hearing aid related services and devices may continue to use them. (See WAC 296-23-165 section 1(b).) Self-insurers who do not have hearing aid purchasing contracts must follow L&I's maximum fee schedule and purchasing policies for all hearing aid services and devices listed in this section.

AUTHORIZATION REQUIREMENTS

Initial and Subsequent Hearing Related Services

Prior authorization must be obtained from the insurer for all initial and subsequent hearing related services, devices, supplies and accessories in accordance with WAC 296-20-03001 and WAC 296-20-1101. The insurer will not pay for hearing devices provided prior to authorization.

> **NOTE:** In cases of special need, such as when the worker is working and a safety issue exists, the provider may be able to obtain the insurer's authorization to dispense hearing aid(s) after the doctor's examination and before the claim is accepted.The insurer will notify the worker in writing when the claim is accepted or denied.

The authorization process for State Fund claims may be initiated by calling the claim manager or the State Fund's Provider Hotline at 1-800-848-0811 (in Olympia call 902-6500).

For self-insured claims the provider should obtain **prior authorization** from the self-insurer or its third party administrator. Self-insurers can contract with a provider and can require the worker to obtain hearing related services and devices through the contracted provider.

Trial Period

A 30-day trial period is the standard established by RCW 18.35. During this time, the provider supplying the aids must allow workers to have their hearing aids adjusted or be returned without cost for the aids and without restrictions beyond the manufacturer's requirements (for example, hearing aids are not damaged). Follow up hearing aid adjustments are bundled into the dispensing fee. If hearing aids are returned within the 30-day trial period for workers covered by the State Fund, the provider must refund the hearing aid and dispensing fee.

Types of Hearing Aids Authorized

The insurer will purchase hearing aids of appropriate technology to meet the worker's needs (for example, digital). Decision will be based on recommendations from physicians, ARNPs, licensed audiologists or fitter/dispensers. Based on current technology, the types of hearing aids purchased for most workers are digital or programmable in the ear (ITE), in the canal (ITC) and behind the ear (BTE).

The insurer may consider completely in the canal (CIC) aid(s) if the physician, ARNP, audiologist or fitter/dispenser documents why CIC is needed. A written professional opinion justifying CIC aids must be submitted to the insurer.

Any other types of hearing aids needed for medical conditions will be considered based on justifications from the physician, ARNP, licensed audiologist or fitter/dispenser. L&I will not purchase used equipment.

Hearing Aid Quality

All hearing aid devices provided to workers must meet or exceed all Food and Drug Administration (FDA) standards. All manufacturers and assemblers must hold a valid FDA certificate.

Special Authorization for Hearing Aids Over $900

If the manufacturer's invoice cost of any hearing aid exceeds $900 including shipping and handling, contact the claim manager for special authorization, as a review may be required.

> **Exception:** The cost of BTE ear molds does not count toward the $900 for special authorization. Initial BTE ear molds may be billed using V5264 and replacements may be billed using V5014 with V5264.

Authorized Testing

Testing to fit a hearing aid may be done by a licensed audiologist, fitter/dispenser, qualified physician or qualified ARNP. Obtain **prior authorization** for subsequent testing. The insurer does not pay for testing after a claim has closed.

If free initial hearing screenings are offered to the public, the insurer will not pay for these services.

Required Documentation

The insurer will authorize hearing aids only when prescribed or recommended by a physician or ARNP and the claim for hearing loss has been allowed. State Fund claim managers use the information outlined below to decide whether an individual worker has a valid work-related hearing loss (a self-insurer or its third party administrator may use similar forms to gather information).

- Report of Accident
- Occupational Disease Employment History Hearing Loss (F262-013-000; F262-013-111 continuation)
- Occupational Hearing Loss Questionnaire (F262-016-000)
- Valid audiogram
- Medical report
- Hearing Services Worker Information (F245-049-000)
- Authorization to Release Information (F262-005-000)

PAYMENT FOR AUDIOLOGY SERVICES

The insurer **does not pay** any provider or worker to fill out the Employment History Hearing Loss or Occupational Hearing Loss Questionnaire.

Physicians or ARNPs may be paid for a narrative assessment of work-relatedness to the hearing loss condition. Refer to the *Attending Doctors Handbook* table on Other Miscellaneous Codes and Descriptions.

The insurer **will pay** for the cost of battery replacement for the life of an authorized hearing aid. No more than 1 box of batteries (40) will be paid within each 90-day period.

> **NOTE:** Sending workers batteries that they have not requested and for which they do not have an immediate need is in violation of L&I's rules and payment policies.

The insurer **will not pay** for any repairs including parts and labor within the manufacturer's warranty period.

Hearing Aid Parts and Supplies Paid at Acquisition Cost

Parts and supplies **must be billed** and **will be paid** at acquisition cost including volume discounts (manufacturers' wholesale invoice). **Do not bill** your usual and customary fee.

- Supply items for hearing aids include tubing, wax guards, batteries and ear hooks. These can be billed within the warranty period.
- Parts for hearing aids include switches, controls, filters, battery doors and volume control covers. These can be billed as replacement parts only, but not within the warranty period.
- Shells ("ear molds" in HCPCS codes) and other parts can be billed separately at acquisition cost. L&I **does not cover** disposable shells.

Hearing aid extra parts, options, circuits and switches, for example, T-coil and noise reduction switch, can only be billed when the manufacturer does not include these in the base invoice for the hearing aid.

Batteries

Only 1 box of batteries (40) is authorized within each 90 day period. Providers must document the request for batteries by the worker and must maintain proof that the worker actually received the batteries.

> **NOTE:** Sending workers batteries that they have not requested and for which they do not have an immediate need is in violation of L&I's rules and payment policies.

Worker Responsible for Devices That Are Not Medically Necessary

The insurer is responsible for paying for hearing related services and hearing aids that are deemed medically necessary. In the event a worker refuses the recommendations given in his/her case and wants to purchase different hearing aids, the worker then becomes totally responsible for the purchase of the hearing aid, batteries, supplies and any future repairs.

Worker Responsible for Some Repairs, Losses, Damages

Workers are responsible for paying for repairs and batteries to hearing aids not authorized by the insurer. The worker is also responsible for nonwork related losses or damages to their hearing aid(s), for example, worker's pet eats/chews the hearing aid, etc. In no case will the insurer cover this type of damage. In these instances, the worker will be required to buy a hearing aid consistent with current L&I guidelines.

After purchase and submission of the new warranty to the insurer, the insurer will resume paying for batteries and repairs following the hearing aid payment policies.

REPAIRS AND REPLACEMENTS

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Warranties

Hearing aid industry standards provide a minimum of a 1 year repair warranty on most hearing devices, which includes parts and labor. Where a manufacturer provides a warranty greater than 1 year, the manufacturer's warranty will apply.

The manufacturer's warranty and any additional provider warranty must be submitted in hard copy to the insurer for all hearing devices and hearing aid repairs.

The warranty should include the make, model and serial number of the individual hearing aid.

Some wholesale companies' warranties also include a replacement policy to pay for hearing aids that are lost. If the hearing aid loss is **covered** under the warranty, the provider must honor the warranty and replace the worker's lost hearing aid without charge.

The insurer does not purchase or provide additional manufacturers' or extended warranties

beyond the initial manufacturer's warranty (or any additional provider warranty).

The insurer **will not pay** for any repairs including parts and labor within the manufacturer's warranty period.

- The warranty begins on the date the hearing aid is dispensed to the worker
- For repairs, the warranty begins when the hearing aid is returned to the worker

Prior Authorization Required

Prior authorization is required for all billed repairs.

The insurer will repair hearing aids and devices when needed due to normal wear and tear.

- At its discretion, the insurer may repair hearing aids and devices under other circumstances
- After the manufacturer's warranty expires, the insurer will pay for the cost of appropriate repairs for the hearing aids they authorized and purchased
- If the aid is damaged in a work-related incident, the worker may file a new claim

Audiologists and fitters/dispensers may be paid for providing authorized in-office repairs. Authorized in-office repairs must be billed using V5014 and V5267.

For authorization of in-office repairs or repairs by the manufacturer, or an all-make repair company, providers must submit a written estimate of the repair cost to the State Fund Provider Hotline or to the insurer's claim manager.

Replacement

The insurer does not provide an automatic replacement period.

Documentation that a hearing aid is not repairable may be submitted by licensed audiologists, fitter/dispensers, all-make repair companies or FDA certified manufacturers. Documentation to support a hearing aid as not repairable must be verified by:

- All-make repair companies or
- FDA certified manufacturers/repair facilities

If only 1 of the binaural analog hearing aids is not repairable and if, in the professional's opinion both hearing aids need to be replaced, the provider must submit logical rationale for the claim manager's consideration.

The insurer will replace hearing aids when they are not repairable due to normal wear and tear.

- At its discretion, the insurer may replace hearing aids in other circumstances
- Replacement is defined as purchasing a hearing aid for the worker according to L&I's most current guidelines
- The insurer may replace the hearing aid exterior (shell) when a worker has ear canal changes or the shell is cracked. The insurer **will not pay** for new hearing aids when only new ear shell(s) are needed.
- The insurer **will not replace** a hearing aid due to hearing loss changes, unless the new degree of hearing loss was due to continued on-the-job exposure. A new claim must be filed with the insurer if further hearing loss is a result of continued work-related exposure or injury, or the aid is lost or damaged in a work-related incident.
- The insurer **will not pay** for new hearing aids for hearing loss resulting from: noise exposure that occurs outside the workplace; nonwork related diseases and conditions **or** the natural aging process

The worker must sign and be given a copy of the Worker Information Form (F245-049-000). The provider must submit a copy of the signed form with the replacement request.

Linear Analog Hearing Aid Replacement Policy

Linear analog hearing aids may be replaced with non-linear digital or analog hearing aids under the following conditions:

- The worker returns a linear analog hearing aid to their dispenser or audiologist because:
- The hearing aid is inoperable or
- The worker is experiencing an inability to hear, and
- The insurer has given prior authorization to replace the hearing aid.

The associated professional fitting fee (dispensing fee) will also be paid when the replacement of linear analog with non-linear digital or analog hearing aid is authorized.

Providers must use modifier *RP* with the appropriate hearing aid HCPCS code to be paid for the replacement aid. The *RP* modifier is required to help the insurer track utilization of the replacement hearing aids.

Who Can Bill

Audiologists, physicians, ARNPs and fitter/dispensers who have current L&I provider account numbers. You may bill for the acquisition cost of the non-linear aids and the associated professional fitting fee (dispensing fee).

Authorization Requirements

Prior authorization must be obtained from the insurer **before** replacing linear analog hearing aids. The insurer **will not pay** for replacement hearing aids issued prior to authorization.

For State Fund claims

- Call the claim manager or
- Fax the request to the State Fund's Provider Hotline at **360-902-6490**.

For Self-Insured claims

Contact the self-insured employer or their third party administrator for prior authorization.

Authorization Documentation and Record Keeping Requirements

Before authorizing replacement, the insurer will require and request the following documentation from the provider:

- A separate statement (signed by both the provider and the injured worker): "This linear analog replacement request is sent in accordance with L&I's linear analog hearing aid replacement policy." (required)
- Completed Hearing Services Worker Information form (required for State Fund claims only). Available at: http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2032
- Serial number(s) of the current linear analog aid(s), if available.
- Make/Model of the current liner analog aid(s), if available.
- Date original hearing aid(s) issued to injured worker, if available.

DOCUMENTATION AND RECORD KEEPING REQUIREMENTS

Documentation to Support Initial Authorization

Providers must keep **all** of the following information in the worker's medical records and submit a copy to the insurer:

- Name and title of referring practitioner, if applicable and
- Complete hearing loss history, including whether the onset of hearing loss was sudden or gradual and
- Associated symptoms including, but not limited to, tinnitus, vertigo, drainage, earaches, chronic dizziness, nausea and fever and
- A record of whether the worker has been treated for recent or frequent ear infections; and
- Results of the ear examination and
- Results of all hearing and speech tests from initial examination and
- Review and comment on historical hearing tests, if applicable and
- All applicable manufacturers' warranties (length and coverage) plus the make, model and serial number of any hearing aid device(s) supplied to the worker as original or as a replacement and
- Original or unaltered copies of manufacturers' invoices and
- Copy of the Hearing Services Worker Information form signed by the worker and provider and
- Invoices and/or records of all repairs.

Documentation to Support Repair

The provider who arranges for repairs to hearing aid(s) authorized or purchased by the insurer must submit records of all repairs to these aids to the insurer. These records are required, even during the warranty period.

Documentation to Support Replacement

The following information must be submitted to the insurer when requesting authorization for hearing aid replacement.

- The name and credential of the person who inspected the hearing aid and
- Date of the inspection and
- Observations, for example, a description of the damage, and/or information on why the device cannot be repaired or should be replaced.

Correspondence with the Insurer

The insurer may deny payment of the provider's bill if the following information has not been received.

- Original or unaltered wholesale invoices from the manufacturer are required to show the acquisition cost and must be retained in the provider's office records for a minimum of 5 years
- A hard copy of the original or unaltered manufacturer's wholesale invoice must be submitted by the provider when an individual hearing aid, part or supply costs $150.00 or more, or upon the insurer's request

  NOTE: Electronic billing providers must submit a hard copy of the original or unaltered manufacturer's wholesale invoice with the make, model and serial number for individual hearing aids within 5 days of bill submission.

To avoid delays in processing, all correspondence to the insurer must indicate the worker's name and claim number in the upper right hand corner of each page of the document.

For State Fund claims, providers are required to send warranty information to:

Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291

ADVERTISING LIMITS

L&I can deny a provider's application to provide services or suspend or revoke an existing provider account if the provider participates in false, misleading or deceptive advertising or misrepresentations of industrial insurance benefits. See RCW 51.36.130 and WAC 296-20-015 for more information.

False advertising includes mailers and advertisements that:

- Suggest a worker's hearing aids are obsolete and need replacement and
- Do not clearly document a specific hearing aid's failure.

BILLING REQUIREMENTS

Billing for Binaural Hearing Aids

When billing the insurer for hearing aids for both ears, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for each side of the body (right/left)
- Bill the appropriate HCPCS code for binaural aids
- Only 1 unit of service should be billed even though 2 hearing aids (binaural aids) are dispensed

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format.

Billing for a Monaural Hearing Aid

When billing the insurer for 1 hearing aid, providers must indicate on the CMS-1500 or Statement for Miscellaneous Services form the following:

- In the diagnosis/nature of injury description box, list the diagnosis, as appropriate, for the side of the body (right/left) affected
- Bill the appropriate HCPCS code for monaural aid
- Only 1 unit of service should be billed

NOTE: Electronic billers are to use the appropriate field for the diagnosis code and side of body, specific to their electronic billing format

Billing for Hearing Aids, Devices, Supplies, Parts and Services

All hearing aids, parts and supplies must be billed using HCPCS codes. Hearing aids and devices are considered to be durable medical equipment and must be billed at their acquisition cost. Refer to the Acquisition Cost Policy , page **117**, for more detail.

The table below indicates what services and devices are **covered** by provider type.

Provider Type	Service/Device
Fitter/dispenser	HCPCS codes for all hearing related services and devices
Durable Medical Equipment providers	Supply and battery codes
Physician, ARNP, Licensed Audiologist	HCPCS codes for hearing related services and devices; and CPT® codes for hearing-related testing and office calls

AUTHORIZED FEES

Dispensing Fees

Dispensing fees cover a 30-day trial period during which all aids may be returned. Also included:

- Up to 4 follow up visits (ongoing checks of the aid as the wearer adjusts to it) and
- 1 hearing aid cleaning kit and
- Routine cleaning during the first year and
- All handling and delivery fees.

Restocking Fees

The Washington State Department of Health statute (RCW 18.35.185) and rule (WAC 246-828-290) allow hearing instrument fitter/dispensers and licensed audiologists to retain $150 or 15% of the total purchase price, whichever is less, for any hearing aid returned within the rescission period (30 calendar days). This fee is sometimes called a "restocking" fee. Insurers without hearing aid purchasing contracts will pay this fee when a worker rescinds their purchase agreement.

The insurer must receive form F245-050-000 or a statement signed and dated by the provider and the worker. The form must be faxed to L&I at (360) 902-6252 or forwarded to the self-insurer within 2 business days of receipt of the signatures. The provider must submit a refund of the full amount paid by the insurer for the dispensing fees and acquisition cost of the hearing aid that was provided to the worker. The provider may then submit a bill to the insurer for the restocking fee of $150 or 15% of the total purchase price, whichever is less. Use code 5091V. Restocking fees cannot be paid until the insurer has received the refund.

Fee Schedule

The insurer will only purchase the hearing aids, devices, supplies, parts and services described in the fee schedule.

HCPCS Code	Description	Maximum Fee
V5008	Hearing screening	$ 76.55
V5010	Assessment for hearing aid	Bundled
V5011	Fitting/orientation/checking of hearing aid	Bundled
V5014	Hearing aid repair/modifying visit per ear (bill repair with code 5093V)	$ 51.04
V5020	Conformity evaluation (1 visit allowed after the 30-day trial period)	Bundled
V5030	Hearing aid, monaural, body worn, air conduction	Acquisition cost
V5040	Body-worn hearing aid, bone	Acquisition cost
V5050	Hearing aid, monaural, in the ear	Acquisition cost
V5060	Hearing aid, monaural, behind the ear	Acquisition cost
V5070	Glasses air conduction	Acquisition cost
V5080	Glasses bone conduction	Acquisition cost
V5090	Dispensing fee, unspecified hearing aid	Not covered
V5100	Hearing aid, bilateral, body worn	Acquisition cost
V5110	Dispensing fee, bilateral	Not covered
V5120	Binaural, body	Acquisition cost
V5130	Binaural, in the ear	Acquisition cost
V5140	Binaural, behind the ear	Acquisition cost
V5150	Binaural, glasses	Acquisition cost
V5160	Dispensing fee, binaural (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 1449.38
V5170	Hearing aid, cros, in the ear	Acquisition cost

HCPCS Code	Description	Maximum Fee
V5180	Hearing aid, cros, behind the ear	Acquisition cost
V5190	Hearing aid, cros, glasses	Acquisition cost
V5200	Dispensing fee, cros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 868.72
V5210	Hearing aid, bicros, in the ear	Acquisition cost
V5220	Hearing aid, bicros, behind the ear	Acquisition cost
V5230	Hearing aid, bicros, glasses	Acquisition cost
V5240	Dispensing fee, bicros (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 868.72
V5241	Dispensing fee, monaural hearing aid, any type (includes up to 1 conformity eval and 2 follow up visits during the 30-day trial period)	$ 724.69
V5242	Hearing aid, analog, monaural, cic (completely in the ear canal)	Acquisition cost
V5243	Hearing aid, monaural, itc (in the canal)	Acquisition cost
V5244	Hearing aid, digitally programmable analog, monaural, cic	Acquisition cost
V5245	Hearing aid, digitally programmable, analog, monaural, itc	Acquisition cost
V5246	Hearing aid, digitally programmable analog, monaural, ite (in the ear)	Acquisition cost
V5247	Hearing aid, digitally programmable analog, monaural, bte (behind the ear)	Acquisition cost
V5248	Hearing aid, analog, binaural, cic	Acquisition cost
V5249	Hearing aid, analog, binaural, itc	Acquisition cost
V5250	Hearing aid, digitally programmable analog, binaural, cic	Acquisition cost
V5251	Hearing aid, digitally programmable analog, binaural, itc	Acquisition cost
V5252	Hearing aid, digitally programmable, binaural, ite	Acquisition cost
V5253	Hearing aid, digitally programmable, binaural, bte	Acquisition cost
V5254	Hearing aid, digital, monaural, cic	Acquisition cost
V5255	Hearing aid, digital, monaural, itc	Acquisition cost
V5256	Hearing aid, digital, monaural, ite	Acquisition cost
V5257	Hearing aid, digital, monaural, bte	Acquisition cost
V5258	Hearing aid, digital, binaural, cic	Acquisition cost
V5259	Hearing aid, digital, binaural, itc	Acquisition cost
V5260	Hearing aid, digital, binaural, ite	Acquisition cost
V5261	Hearing aid, digital, binaural, bte	Acquisition cost
V5262	Hearing aid, disposable, any type, monaural	Not covered
V5263	Hearing aid, disposable, any type, binaural	Not covered
V5264	Ear mold (shell)/insert, not disposable, any type	Acquisition cost
V5265	Ear mold (shell)/insert, disposable, any type	Not covered
V5266	Battery for hearing device	$ 0.88
V5267	Hearing aid supply/accessory	Acquisition cost

L&I Specialty Codes	Description	Maximum Fee
5091V	Hearing aid restocking fee (the lesser of 15% of the hearing aid total purchase price or $150 per hearing aid)	By report
5092V	Hearing aid cleaning visit per ear (1 every 90 day, after the first year)	$ 23.81
5093V	Hearing aid repair fee. Manufacturer's invoice required	By report

INTERPRETIVE SERVICES

INFORMATION FOR HEALTH CARE AND VOCATIONAL PROVIDERS

Workers or crime victims (insured individuals) who have limited English proficiency or sensory impairments may need interpretive services in order to effectively communicate with providers. Interpretive services do not require **prior authorization**.

Under the Civil Rights Act of 1964, the health care or vocational provider will determine whether effective communication is occurring. If assistance is needed, the health care or vocational provider selects an interpreter to facilitate communication. The health care or vocational provider determines if an interpreter accompanying (whether paid or unpaid) the insured meets the communication needs. If a different interpreter is needed, the insured may be consulted in the selection process. Sensitivity to the insured's cultural background and gender is encouraged when selecting an interpreter. Either paid or non-paid interpreters may assist with communications. In all cases, the paid interpreter selected must meet the credentialing standards contained in this policy. Persons identified as ineligible to provide services in this policy may not be used even if they are unpaid. Please review the sections related to eligible and ineligible interpretive services providers. Persons under age 18 may not interpret for workers or crime victims.

For paid interpreters, healthcare or vocational providers or their staff must verify services on the Interpretive Services Appointment Record (F245-056-000) or a similar interpreter provider's verification form which will be presented by the interpreter at the end of the appointment. Providers should also note in their records that an interpreter was used at the appointment. When a procedure requires informed consent, a credentialed interpreter should help you explain the information.

POLICY APPLICATION

This policy applies to interpretive services provided for health care and vocational services in all geographic locations to workers and crime victims (collectively referred to as "insured") having limited English proficiency or sensory impairment; and receiving benefits from the following insurers:

- The State Fund (L&I) or
- Self-Insured Employers or
- The Crime Victims Compensation Program.

This policy does not apply to interpretive services for workers or crime victims for legal purposes, including but not limited to:

- Attorney appointments
- Legal conferences
- Testimony at the Board of Industrial Insurance Appeals or any court
- Depositions at any level

Payment in these circumstances is the responsibility of the attorney or other requesting party(s).

CREDENTIALS REQUIRED FOR L&I PROVIDER ACCOUNT NUMBER

Interpreters and translators must have an L&I provider account. To obtain an L&I interpretive services provider account number, an interpreter or translator must submit credentials using the "Submission of Provider Credentials for Interpretive Services" form F245-055-000. Credentials accepted include those listed below under "Certified Interpreter" and "Certified Translator" or "Qualified Interpreter" or "Qualified Translator".

Interpreters and translators located outside of Washington State must submit credentials from their state Medicaid programs, state or national court systems or other nationally recognized programs.

For interpretive services providers in any geographic location, credentials submitted from agencies or organizations other than those listed below may be accepted if the testing criteria can be verified as meeting the minimum standards listed below:

Interpreter test(s) consists of, at minimum:	Document translation test(s) consists of, at minimum:
A verbal test of sight translation in both English and other tested language(s); **and**	A written test in English and in the other language(s) tested; **or**
A written test in English; **and**	A written test and work samples demonstrating the ability to accurately translate from one specific source language to another specific target language
A verbal test of consecutive interpretation in both languages; **and**	
For those providing services in a legal setting, a verbal test of simultaneous interpretation in both languages	

Certified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Washington State Department of Social and Health Services (DSHS)	Social or Medical Certificate, or Provisional Certificate
Washington State Administrative Office for the Courts (AOC)	Certificate
RID-NAD National Interpreter Certification (NIC)	Certified Advanced (Level 2), or Certified Expert (Level 3)
Registry of Interpreters for the Deaf (RID)	Comprehensive Skills Certificate (CSC), or Master Comprehensive Skills Certificate (MSC), or Certified Deaf Interpreter (CID), or Specialist Certificate: Legal (SC:L), or Certificate of Interpretation and Certificate of Transliteration (CI/CT)
National Association for the Deaf (NAD)	Level 4, or Level 5
Federal Court Interpreter Certification Test (FCICE)	Certificate
US State Department Office of Language Services	Verification letter or Certificate

Qualified Interpreter

Interpreter who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Translators and Interpreters Guild	Certificate
Washington State Department of Social and Health Services (DSHS)	Letter of authorization as a qualified social and/or medical services interpreter including provisional authorization
Federal Court Interpreter Certification Examination (FCICE)	Letter of designation or authorization

Certified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
Washington State Department of Social and Health Services (DSHS)	Translator Certificate
Translators and Interpreters Guild	Certificate
American Translators Association	Certificate

Qualified Translator

Translator who holds credentials in good standing from 1 or more of the following:

Agency or Organization	Credential
A state or federal agency; A state or federal court system; Other organization including language agencies; and/or An accredited academic institution of higher education.	Certificate or other verification showing: Successful completion of an examination or test of written language fluency in both English and in the other tested language(s); and A minimum of 2 years experience in document translation.

Maintaining Credentials

Interpretive services providers are responsible for maintaining their credentials as required by the credentialing agency or organization. Should the interpretive services provider's credentials expire or be removed for cause or any other reason, the provider must immediately notify the insurer(s).

Credentialed Employees of Health Care and Vocational Providers

Credentialed employees of health care and vocational providers are eligible to receive payment for interpretive services under the following circumstances:

- The individual's sole responsibility is to assist patients or clients with language or sensory limitations and
- The individual is a credentialed interpreter or translator and
- The individual has an L&I provider account number for interpretive services.

Interpreters/Translators Not Eligible for Payment

Other persons may on occasion assist the worker or crime victim with language or communication limitations. These persons do not require a provider account number, but also **will not be paid** for interpretive services. These persons may include but are not limited to:

- Family members
- Friends or acquaintances
- The healthcare or vocational provider
- Employee(s) of the health care or vocational provider whose primary job is not interpretation
- Employee(s) of the health care or vocational provider whose primary job is interpretation but who is not a credentialed interpreter or translator
- Interpreters/Translators not complying with all applicable state and/or federal licensing or certification requirements, including but not limited to, business licenses as they apply to the specific provider's practice or business

Persons Ineligible to Provide Interpretation/Translation Services

Some persons may not provide interpretation or translation services for workers or crime victims during health care or vocational services delivered for their claim. These persons are:

- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative
- The employer's legal or lay representative or employees of the legal or lay representative
- Persons under age 18

  NOTE: Workers or crime victims using children for interpretation purposes should be advised they need to have an adult provide these services.

Persons Ineligible to Provide Interpretation/Translation Services at IMEs

Under WAC 296-23-362(3), "The worker may not bring an interpreter to the examination. If interpretive services are needed, the insurer will provide an interpreter." Therefore, at Independent Medical Examinations (IMEs), persons (including interpreter/translator providers with account numbers) who may not provide interpretation or translation services for workers or crime victims are:

- Those related to the worker or crime victim
- Those with an existing personal relationship with the worker or crime victim
- The worker's or crime victim's legal or lay representative or employees of the legal or lay representative
- The employer's legal or lay representative or employees of the legal or lay representative
- Any person who could not be an impartial and independent witness
- Persons under age 18

Hospitals and other facilities may have additional requirements

Hospitals, free standing surgery and emergency centers, nursing homes and other facilities may have additional requirements for persons providing services within the facility. For example, a facility may require all persons delivering services to have a criminal background check, even if the provider is not a contractor or employee of the facility. The facility is responsible for notifying the interpretive services provider of their additional requirements and managing compliance with the facilities' requirements.

PRIOR AUTHORIZATION

Services not requiring prior authorization

Direct interpretive services (either group or individual) and mileage do not require **prior authorization** on open claims. Providers can check claim status with the insurer prior to service delivery.

Services prior to claim allowance are not payable except for the initial visit. If the claim is later allowed, the insurer will determine which services rendered prior to claim allowance are payable.

Only services to assist in completing the reopening application and for insured requested IME are payable unless or until a decision is made. If a claim is reopened, the insurer will determine which other services are payable.

Services requested by the insurer or requiring prior authorization

IME Interpretation services

When an IME is scheduled, the insurer will arrange for the interpretive services. **Prior authorization** is not required. The insured may ask the insurer to use a specific interpreter. However, only the interpreter scheduled by the insurer will be paid for IME interpretive services. Interpreters who accompany the insured, without insurer approval, will not be paid nor allowed to interpret at the IME.

IME No Shows

Authorization must be obtained prior to payment for an IME no show. For State Fund claims, contact the Central Scheduling Unit supervisor at 206-515-2799 after occurrence of IME no show. Per WAC 296-20-010(5) "No fee is payable for missed appointments unless the appointment is for an examination arranged by L&I or self-insurer."

Document translation

Document translation services are only paid when performed at the request of the insurer. Services will be authorized before the request packet is sent to the translators.

COVERED AND NONCOVERED SERVICES

Covered and may be billed to the insurer.

Payment is dependent upon service limits and L&I policy:

- Interpretive services which facilitate language communication between the insured and a health care or vocational provider
- Time spent waiting for an appointment that does not begin at time scheduled (when no other billable services are being delivered during the wait time)
- Assisting the insured to complete forms required by the insurer and/or health care or vocational provider
- A flat fee for an insurer requested IME appointment when the insured does not attend
- Translating document(s) at the insurer's request
- Miles driven from a point of origin to a destination point and return

Not covered and may not be billed to nor will they be paid by the insurer:

- Services provided for a denied or closed claim (except services associated with the initial visit for an injury or crime victim claim or the visit for the insured's application to reopen a claim)
- No show for any service other than an insurer requested IME (for example, physical therapy visits)
- Personal assistance on behalf of the insured such as scheduling appointments, translating correspondence or making phone calls
- Document translation requested by anyone other than the insurer, including the insured
- Services provided for communication between the insured and an attorney or lay worker representative
- Services provided for communication not related to the insured's communications with health care or vocational providers
- Travel time and travel related expenses such as meals, parking, lodging
- Overhead costs, such as phone calls, photocopying and preparation of bills

FEES, SERVICE DESCRIPTIONS AND LIMITS

The coverage and payment policy for interpretive services is listed below:

Code	Description	Units of Service	Maximum Fee	L&I Authorization and Limit Information
9988M	Group Interpretation Direct services time between more than one client(s) and health care or vocational provider, includes wait and form completion time, time divided between all clients participating in group, per minute	1 minute equals 1 unit of service	$0.88 per minute	Limited to 480 minutes per day Does not require prior authorization
9989M	Individual Interpretation Direct services time between insured and health care or vocational provider, includes wait and form completion time, per minute	1 minute equals 1 unit of service	$0.88 per minute	Limited to 480 minutes per day Does not require prior authorization
9986M	Mileage, per mile	1 mile equals 1 unit of service	State rate	Mileage billed over 200 miles per claim per day will be reviewed Does not require prior authorization
9996M	Interpreter “IME no show” Wait time when insured does not attend the insurer requested IME, flat fee	Bill 1 unit per worker no show at IME	Flat fee $52.74 Mileage to and from appointment will also be paid	Payment requires prior authorization Contact Central Scheduling Unit after no show occurs at 260-515-2799 Only 1 no show per worker per day
9997M	Document Translation, at insurer request	1 page equals 1 unit of service	By report	Authorization will be documented on translation request packet. Over $500 per claim will be reviewed

BILLING FOR INTERPRETIVE SERVICES

Interpretive services providers use the miscellaneous bill form and billing instructions.

Individual Interpretation Services

Services delivered for a single client include interpretation performed with the insured and a health care or vocational provider, form completion and wait time. Only the time spent actually delivering those services may be billed. Time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services ended. If there are breaks in service due to travel between places of service delivery, this time must be deducted from the total time billed. See the Billing Examples for further information.

Group Interpretation Services

When interpretive services are delivered for more than 1 person (regardless of whether all are workers and/or crime victims), the time spent must be prorated between the participants. For example, if 3 persons are receiving a 1 hour group physical therapy session at different stations and the interpretive services provider is assisting the physical therapist with all 3 persons, the interpretive services provider must bill only 20 minutes per person. The time is counted from when the appointment is scheduled to begin or when the interpreter arrives, whichever is later, to when the services end. See the Billing Examples for further information.

The combined total of both individual and group services is limited to 480 minutes (8 hours) per day.

IME No Show

Per WAC 296.20.010 (5) only services related to No Shows for insurer requested IMEs will be paid. The insurer will pay a flat fee for IME no show. Mileage to and from the appointment will also be paid.

Mileage and Travel

Insurers will not pay interpretive service providers travel time or for travel expenses such as hotel, meals, parking, etc.

Interpretive service providers may bill for actual miles driven to perform interpretation services for an individual client or group of clients. When mileage is for services to more than 1 person (regardless of whether all are workers and/or crime victims), the mileage must be prorated between all the persons served. Mileage between appointments on the same day should be split between the clients. Mileage is payable for missed or no show appointments. See the Billing Examples for further information. Mileage over 200 miles per day will be reviewed for necessity such as rare language and/or remote location.

Document Translation Services

Document translation is an insurer generated service. Payment for document translation will be made only if the service was requested by the insurer. If anyone other than the insurer requests assistance with document translation, the insurer must be contacted before services can be delivered.

Billing Examples

Example 1 – Individual Interpretive Services

Example Scenario	Time Frames	Type of Service	Code and Units to Bill
Interpreter drives 8 miles from his place of business to the location of an appointment for an worker	Not applicable	Mileage	8 units 9986M
Worker has an 8:45 a.m. appointment. The interpreter and insured enter the exam room at 9:00 a.m. The exam takes 20 minutes. The health care provider leaves the room for 5 minutes and returns with a prescription and an order for X-rays for the insured. The appointment ends at 9:30 a.m.	8:45 a.m. to 9:30 a.m.	Individual Interpretive Services	45 units 9989M
Interpreter drives 4 miles to X-ray service provider and meets insured.	Not applicable	Mileage	4 units 9986M
Interpreter and insured arrive at the radiology facility at 9:45 a.m. and wait 15 minutes for X-rays which takes 15 minutes. They wait 10 minutes to verify X-rays do not need to be repeated.	9:45 a.m. to 10:25 a.m.	Individual Interpretive Services	40 units 9989M
Interpreter drives 2 miles to pharmacy and meets insured.	Not applicable	Mileage	2 units 9986M
The worker and the interpreter arrive at the pharmacy at 10:35 a.m. and wait 15 minutes at the pharmacy for prescription. The interpreter explains the directions to the worker which takes 10 minutes.	10:35 a.m. to 11 a.m.	Individual Interpretive Services	25 units 9989M
After completing the services, the interpreter drives 10 miles to the next interpretive services appointment. The interpreter splits the mileage between the worker and the next client if this is not the last appointment of the day	Not applicable	Mileage	5 units 9986M
Total billable services for the scenario	Individual Interpretive Services Mileage		110 units 9989M 19 units 9986M

Example 2 – Group Interpretive Services			
Example Scenario	**Time Frames**	**Type of Service**	**Code and units to Bill**
Interpreter drives 9 miles from his place of business to the location of an appointment for 3 clients. 2 are insured by the state fund.	Not applicable	Mileage	3 units of 9986M to each state fund claim
The 3 clients begin a physical therapy appointment at 9:00 a.m. The interpreter circulates between the 3 clients during the appointment which ends at 10 a.m.	9 a.m. to 10 a.m.	Group Interpretive Services	20 units of 9988M to each state fund claim
After completing the appointment the interpreter drives 12 miles to next appointment location. The interpreter splits the mileage between the 3 clients and the next client if this is not the last appointment of the day (12 divided by 2=6; 6 divided by 3=2).	Not applicable	Mileage	2 units 9986M to each state fund claim
Total billable services for the scenario	Group Interpretive Services Mileage Billed to EACH state fund claim		20 units 9988M 5 units 9986M

DOCUMENTATION REQUIREMENTS

Interpretive service appointment and mileage documentation must be submitted to L&I when the services are billed.

Billing Tip

Do not staple documentation to bill forms. Send documentation separately from bills for State Fund or Crime Victims Compensation Program claims to:

State Fund
Department of Labor and Industries
PO Box 44291
Olympia, WA 98504-4291
360-902-6500
1-800-848-0811

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia, WA 98504-4520
360-902-5377
1-800-762-3716

Self-insurer
Varies – to determine insurer call 360-902-6901 OR see Self-insurer list at http://www.LNI.wa.gov/ClaimsIns/Providers/billing/billSIEmp/default.asp

Interpretive Services Appointment Documentation

- Direct interpretive services must be recorded on the L&I "Interpretive Services Appointment Record" form F245-056-000. Copies can be obtained on L&I's website or a supply of forms can be ordered from the warehouse. Interpretive services providers may also use their own encounter forms to document services, meeting the criteria listed below.
- Provider or agency encounter forms used in lieu of L&I's Interpretive Services Appointment Record **must** have the following information:
  - Claim number, claimant full name and date of injury in upper right hand corner of form
  - Interpreter name and agency name (if applicable)
  - Encounter (appointment) information including:
  - Health care or vocational provider name
  - Appointment address
  - Appointment date
  - Appointment start time
  - Interpreter arrival time
  - Appointment completion time
  - If a group appointment, total number of clients (not health care or vocational providers) participating in the group appointment
  - Actual mileage information including:
  - Actual miles from starting location (including street address) to appointment
  - Actual miles (not prorated) from appointment to next appointment or return to starting location (include street address)
  - Actual total miles
  - Verification of appointment by health care or vocational provider
  - Printed name and signature of person verifying services
  - Date signed

  NOTE: All agency encounter and Interpretive Services Appointment Record forms must be signed by the health care or vocational provider or their staff to verify services including mileage for missed appointments or IME no shows.

Mileage Documentation

Include mileage documentation that supports the number of miles between appointments. Documentation can be:

- Odometer readings or
- Printout from a software mileage program and name of software program used

Translation Services Documentation

Documentation for translation services must include:

- Date of service and
- Description of document translated (letter, order and notice, medical records) and
- Total number of pages translated and
- Total words translated and
- Target and source languages.

STANDARDS FOR INTERPRETIVE SERVICES PROVIDER CONDUCT

L&I is responsible for assuring workers and crime victims receive proper and necessary services. The following requirements set forth the insurer's expectations for quality interpretive services.

Accuracy and Completeness

- Interpreters always communicate the source language message in a thorough and accurate manner
- Interpreters do not change, omit or add information during the interpretation assignment, even if asked by the insured or another party
- Interpreters do not filter communications, advocate, mediate, speak on behalf of any party or in any way interfere with the right of individuals to make their own decisions
- Interpreters give consideration to linguistic differences in the source and target languages and preserve the tone and spirit of the source language

Confidentiality

The interpreter must not discuss any information about an interpretation job without specific permission of all parties or unless required by law. This includes content of the assignment such as:

- Time or place
- Identity of persons involved
- Content of discussions
- Purpose of appointment

Impartiality

- The interpreter must not discuss, counsel, refer, advise or give personal opinions or reactions to any of the parties
- The interpreter must turn down the assignment if he or she has a vested interest in the outcome or when any situation, factor or belief exists that represents a real or potential conflict of interest

Competency

Interpreters must meet L&I's credentialing standards and be:

- Fluent in English
- Fluent in the insured's language
- Fluent in medical terminology in both languages
- Willing to decline assignments requiring knowledge or skills beyond their competence

Maintenance of Role Boundaries

- Interpreters must not engage in any other activities that may be thought of as a service other than interpreting (for example, driving the insured to and from appointments).

Responsibilities toward the Insured and the Health Care or Vocational Provider

The interpreter must ensure that all parties understand the interpreter's role and obligations. The interpreter must:

- Inform all parties that everything said during the appointment will be interpreted and they should not say anything they don't want interpreted
- Inform all parties the interpreter will respect the confidentiality of the insured
- Inform all parties the interpreter is required to remain neutral
- Disclose any relationship to any party that may influence or someone could perceive to influence the interpreter's impartiality
- Accurately and completely represent their credentials, training and experiences to all parties

Prohibited Conduct

In addition, interpreters cannot:

- Market their services to workers or crime victims
- Arrange appointments in order to create business
- Contact the worker other than at the request of the insurer or health care or vocational provider
- Provide transportation for the insured to and from health care or vocational appointments.
- Require the insured to use the interpreter provider's services exclusive of other approved L&I interpreters
- Accept any compensation from workers or crime victims or anyone else other than the insurer
- Bill for someone else's services with your individual (not language agency group) provider account number

Working Tips for Interpretive Services Providers

Some things to keep in mind when working as an interpreter on workers' compensation or crime victims' claims:

- Arrive on time
- Always provide identification to the insured and providers
- Introduce yourself to the insured and provider
- Do not sit with the insured in the waiting room unless assisting them with form completion
- Acknowledge language limitations when they arise and always ask for clarification
- Do not give your home (nonbusiness) telephone number to the insured or providers
- Complete the Interpreter Services Appointment Record or other qualifying encounter form and mail to L&I

OTHER SERVICES

AFTER HOURS SERVICES

After hours services CPT® codes 99050 - 99060 will be considered for separate payment in the following circumstances:

- When the provider's office is not regularly open during the time the service is provided
- When services are provided on an emergency basis, out of the office, that disrupt other scheduled office visits

After hours service codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

Only 1 code for after hours services will be paid per patient per day, and a 2nd day may not be billed for a single episode of care that carries over from 1 calendar day to the next.

LOCUM TENENS

Modifier –Q6 denotes services furnished by a locum tenens physician.

Modifier –Q6 is **not covered** and L&I **will not pay** for services billed under another provider's account number.

L&I requires all providers to obtain a provider account number to be eligible for payment for services rendered. Refer to WAC 296-20-015 for more information about the requirements.

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the self-insurer makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or self-insurer. Although L&I does not use codes for medical testimony, Self-insurers must allow providers to use CPT® code 99075 to bill for these services. L&I utilizes a separate voucher form titled "A19", which will be provided to you by the Office of the Attorney General , thus providers should not use the CPT® code and L&I cannot provide prepayment for any of these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), but does not include side trips.

The time calculation for testimony, deposition or related work performed in the provider's office or via phone is based upon the actual time used for the testimony or deposition.

The medical witness fee schedule is set pursuant to law, which requires any provider having examined or treated a worker must abide by the fee schedule and testify fully, irrespective of whether paid and called to testify by the Office of the Attorney General or the self-insurer. The Office of the Attorney General or the self-insurer and the provider must cooperate to schedule a reasonable time for the provider's testimony during business hours. Providers must make themselves reasonably available for such testimony within the schedule set by the Board of Industrial Insurance Appeal.

The Office of the Attorney General, not L&I, determines testimony fee and payment policies.

The party requesting interpretive services for depositions or testimony is responsible for payment.

Testimony and Related Fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	$ 100.00/unit* (Maximum of 17 units)
Record review	$ 100.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	$ 100.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 100.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent, which equals $100.00

Testimony and Related Fees (applied to all other health care and vocational providers)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00
Deposition approved in advance by Office of Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00

Testimony and Related Fees (applied to all out of state doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony (live or by deposition)	$ 125.00/unit* (Maximum of 17 units)
Record review	$ 125.00/unit* (Maximum of 25 units)
Conferences (live or by telephone)	$ 125.00/unit* (Maximum of 9 units)
Travel (paid on a portal to portal basis, which is from the time you leave your office until you return, but not to include side trips)	$ 125.00/unit* (Maximum of 17 units)

*1 unit equals 15 minutes of actual time spent, which equals $125.00

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Attorney General/self-insurer **will pay** a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Attorney General/self-insurer **will not pay** a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management (NCM) services require **prior authorization**. Contact the insurer to make a referral for NCM services.

Workers with catastrophic work related injuries and/or workers with medically complex conditions may be selected to receive NCM services.

NCM is a collaborative process used to meet injured or ill worker's health care and rehabilitation needs. NCM is provided by registered nurses with case management certification.

The nurse case manager works with the attending provider, worker, allied health personnel and insurers' staff to assist with coordination of the prescribed treatment plan. Nurse case managers organize and facilitate timely receipt of medical and health care resources and identify potential barriers to medical and/or functional recovery of the worker. They communicate this information to the attending doctor and claim manager, to develop a plan for resolving or addressing the barriers.

Nurse case managers must use the following local codes to bill for NCM services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	$ 9.64
1221M	Visits, per 6 minute unit	$ 9.64
1222M	Case planning, per 6 minute unit	$ 9.64
1223M	Travel/Wait, per 6 minute unit (2 hour limit)	$ 4.74
1224M	Mileage, per mile – greater than 150 miles requires prior authorization from the claim manager	State rate
1225M	Expenses (parking, ferry, toll fees, cab, lodging and airfare) at cost or state per diem rate (meals and lodging). Requires prior authorization from the claim manager	By report

NCM services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

For State Fund claims, **noncovered** expenses include:

- Nurse case manager training
- Supervisory visits
- Postage, printing and photocopying (except medical records requested by L&I)
- Telephone/fax
- Clerical activity
- Travel time to post office or fax machine
- Wait time exceeding 2 hours
- Fees related to legal work, for example, deposition, testimony. Legal fees may be charged to the requesting party, but not the claim
- Any other administrative costs not specifically mentioned above

Case Management Records and Reports

Case management records must be created and maintained on each claim. The record shall present a chronological history of the worker's progress in NCM services.

Case notes shall be written when a service is given and shall specify:

- When the service was provided and
- What type of service was provided using case note codes and
- Description of the service provided including subjective and objective data and
- How much time was used during this reporting period.

NCM reports shall be completed monthly. Payment will be restricted to up to 2 hours for initial reports and up to 1 hour for progress and closure reports. For additional information about billing, refer to the "Nurse Case Management Billing Instructions". Contact the Provider Hotline at 1-800-848-0811 to request a copy.

Report Format

Initial assessment and monthly reports must include **all** of the following information:

- Type of report (initial or progress)
- Worker name and claim number
- Report date and reporting period
- Worker date of birth and date of injury
- Contact information
- Diagnoses
- Reason for referral
- Present status/current medical
- Recommendations
- Actions and dates
- Ability to positively impact a claim
- Health care provider(s) name(s) and contact information
- Psychosocial/economic issues
- Vocational profile
- Hours incurred to date on the referral

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the insurer. The fees listed below include postage for sending documents to the insurer:

Code	Report/Form	Max Fee	Special notes
CPT® 99080	60-Day Report	$ 43.51	60-day reports are required per WAC 296-20-06101 and do not need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of 1 per 60 days per claim.
CPT® 99080	Special Report (Requested by insurer or VRC)	$ 43.51	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit of 1 per day.
1027M	Loss of Earning Power (LEP)	$ 18.93	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.
1040M	Physician's Initial Report – for Self Insured claims	$ 37.84	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form..Paid when initiated by the worker or by a provider listed above. Limit of 1 per claim.

Code	Report/Form	Max Fee	Special notes
1041M	Application to Reopen Claim	$ 49.18	MD, DO, DC, ND, DPM, DDS, ARNP, PA and OD may sign and be paid for completion of this form. May be initiated by the worker or insurer (see WAC 296-20-097). Limit of 1 per request.
1055M	Occupational Disease History Form	$ 183.56	**Must be requested by insurer.** Payable only to attending provider. Includes review of worker information and preparation of report on relationship of occupational history to present condition(s).
1057M	Opioid Progress Report Supplement or any standardized objective tool to evaluate pain and function	$ 30.27	Payable only to attending provider. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days. See WACs 296-20-03021, -03022 and the Labor and Industries Medical Treatment Guidelines. Limit of 1 per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	$ 37.84	**Must be requested by insurer.** Payable only to attending provider. Limit of 1 per request.
1064M	Initial report documenting need for opioid treatment	$ 56.77	Payable only to the attending provider. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and the Labor and Industries Medical Treatment Guidelines for what to include in the report.
1065M	Attending Doctor IME Written Report	$ 28.37	**Must be requested by insurer.** Payable only to attending provider when submitting a separate report of IME review. Limit of 1 per request.
1066M	Provider Review of Video Materials with report	By report	**Must be requested by insurer.** Payable once per provider per day. Report must include actual time spent reviewing the video materials. Not payable in addition to CPT® code 99080 or local codes 1104M or 1198M.
1073M	Insurer Activity Prescription Form (APF)	$49.18	**Must be requested by** insurer. Payable once per provider per worker per day.
1074M	AP response to VRC/Employer request about RTW	$30.27	For communication with vocational counselors (VRC). Team conference, office visit, telephone call, or online communication with a VRC or employer cannot be billed separately.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many L&I forms are available and can be downloaded from http://www.LNI.wa.gov/FormPublications/ and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the insurer using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

S9982 ..... $0.48

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles. This code requires **prior authorization** and usage is limited to extremely rare circumstances.

Code	Description	Max Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	$ 4.86

REVIEW OF JOB OFFERS AND JOB ANALYSES

Attending doctors must review the physical requirements of any job offer submitted by the employer of record and determine whether the worker can perform that job. Whenever the employer asks, the attending doctor should send the employer an estimate of physical capacities or physical restrictions and review each job offer submitted by the employer to determine whether or not the worker can perform that job.

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, nonwork related skills and physical limitations or to determine the worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending providers, independent medical examiners (IME) and consultants will be paid for review of job descriptions or JAs. A job description/JA review may be performed at the request of the State Fund employer, the insurer, vocational rehabilitation counselor (VRC) or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (for example, attorneys or workers) will not be paid. This service does not require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires **prior authorization** and will not be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Max Fee	Special notes
1038M	Review of Job Descriptions or JA	$ 49.18	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Limit of 1 per day. Not payable to IME examiner on the same day as the IME is performed. Code is not payable to IME examiners on day of exam.
1028M	Review of Job Descriptions or JA, each additional review	$ 36.89	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending provider, IME examiner or consultant. Bill to L&I. For IME examiners on day of exam: may be billed for each additional JA after the first 2. For IME examiners after the day of exam: may be billed for each additional JA after the initial (initial is billed using 1038M).

VEHICLE AND HOME MODIFICATIONS

Refer to WAC 296-14-6200 through WAC 296-14-6238 for home modification information. A home modification consultant must be a licensed registered nurse, occupational therapist or physical therapist and trained or experienced in both rehabilitation of catastrophic injuries and in modifying residences. Additional information is available at:

http://www.lni.wa.gov/ClaimsIns/Providers/ProviderIndex/homeMod/default.asp

A vehicle modification consultant must be a licensed occupational or physical therapist, or licensed medical professional with training or experience in rehabilitation and vehicle modification.

Code	Description	Maximum Fee
8914H	Home modification, construction and design. Requires **prior authorization** based on approval by the assistant director of Insurance Services	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification. Requires **prior authorization** based on approval by the assistant director of Insurance Services	Maximum payable for all work is ½ the current Washington state average wage. In the sole discretion of the Supervisor of Industrial Insurance after his or her review, the amount paid may be increased by no more than $4,000 by written order of the Supervisor of Industrial Insurance RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation. Requires **prior authorization**	By report
8917H	Home/vehicle modification mileage, lodging, airfare, car rental. Requires **prior authorization**	State rate
8918H	Vehicle modification, evaluation and consultation. Requires **prior authorization**	By report
0391R	Travel/wait time per 6 minutes. Requires **prior authorization**	$4.83

JOB MODIFICATIONS AND PREJOB ACCOMMODATIONS

The provider of a job modification or pre-job accommodation consultation must be a licensed occupational therapist or physical therapist, vocational rehabilitation provider, or ergonomic specialist.. Vocational rehabilitation counselors and interns in the group assigned to the vocational referral must bill 0823V or 0824V. See Vocational Evaluation on page **150**. The following codes **are payable to**:

- Physical therapists
- Occupational therapists
- Ergonomic specialists
- Vocational rehabilitation counselors not associated with the group assigned to the vocational referral

Code	Description	Maximum Fee
0380R	Job modification (equipment, etc.) Requires **prior authorization** Includes equipment set up and training	Maximum allowable for 0380R is $5,000 per job or job site.
0385R	Prejob accommodation (equipment, etc.) Requires **prior authorization** Includes equipment set up and training	Maximum allowable for 0385R is $5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal cannot exceed $5,000.
0389R	Prejob or job modification consultation, analysis of physical demands (non-VRC), per 6 minutes. Requires **prior authorization**	$ 10.66
0391R	Travel/wait time (non-VRC), per 6 minutes. Requires **prior authorization**	$ 4.83
0392R	Mileage (non-VRC), per mile. Requires **prior authorization**	State rate
0393R	Ferry Charges (non-VRC). Requires **prior authorization**	State rate

Additional information is available at http://www.lni.wa.gov/ClaimsIns/Providers/Vocational/Tools/PreJob/default.asp

If services are provided to a worker with an open vocational referral, see Vocational Evaluation and Related Codes for nonvocational providers on page XXX

VOCATIONAL SERVICES

Vocational Rehabilitation providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions (F248-095-000).

BILLING CODES BY REFERRAL TYPE

All vocational rehabilitation services require **prior authorization**. Vocational rehabilitation services are authorized by referral type. L&I uses 6 referral types.

- Early intervention
- Assessment
- Plan development
- Plan implementation
- Forensic
- Stand alone job analysis

Each referral is a separate authorization for services. L&I will pay interns at 85% of the Vocational Rehabilitation Counselor (VRC) professional rate and forensic evaluators at 120% of the VRC professional rate. All referral types except Forensic are subject to a fee cap (per referral) in addition to the maximum fee per unit. See fee caps, page 152 for more information.

Early Intervention

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0800V	Early Intervention Services (VRC)	$ 8.77
0801V	Early Intervention Services (Intern)	$ 7.47
0802V	Early Intervention Services Extension (VRC)	$ 8.77
0803V	Early Intervention Services Extension (Intern)	$ 7.47

Assessment

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0810V	Assessment Services (VRC)	$ 8.77
0811V	Assessment Services (Intern)	$ 7.47

Vocational Evaluation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0821V	Work Evaluation (VRC)	$ 8.77
0823V	Pre-Job or Job Modification Consultation (VRC)	$ 8.77
0824V	Pre-job or Job Modification Consultation (Intern)	$ 7.47

Plan Development

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0830V	Plan Development Services (VRC)	$ 8.77
0831V	Plan Development Services (Intern)	$ 7.47

Plan Implementation

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0840V	Plan Implementation Services (VRC)	$ 8.77
0841V	Plan Implementation Services (Intern)	$ 7.47

Forensic Services

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0881V	Forensic Services (Forensic VRC)	$ 10.50

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses. This referral type is limited to 15 days from the date the referral was electronically created by the claim manager. Bills for dates of service beyond the 15th day will not be paid.

Code	Description (1 unit = 6 minutes for all codes)	Max Fee Per Unit
0808V	Stand Alone Job Analysis (VRC)	$ 8.77
0809V	Stand Alone Job Analysis (Intern)	$ 7.47
0378R	Stand Alone Job Analysis (non-VRC)	$ 8.77

OTHER BILLING CODES

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC) 1 unit = 6 minutes	$ 4.38
0892V	Travel/Wait Time (Intern) 1 unit = 6 minutes	$ 4.38
0893V	Professional Mileage (VRC) 1 unit = 1 mile	State rate
0894V	Professional Mileage (Intern) 1 unit = 1 mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	By report
0896V	Ferry Charges (VRC, Intern or Forensic VRC)	By report
0897V	Hotel Charges (VRC, Intern or Forensic VRC) [out-of-state only]	By report

Plan Development Services, Nonvocational Providers

L&I established a procedure code to be used for certain services provided during plan development (for example, CDL physicals, background checks, driving abstracts and fingerprinting).

The code must be billed by a medical or a miscellaneous nonphysician provider on a miscellaneous services billing form. The referral ID and referring vocational provider account number must be included on the bill. Limit 1 unit per day, per claim.

The code requires **prior authorization**. Counselors must contact the Unit Vocational Services Consultant to arrange for prior authorization from the claim manager.

The code cannot be used to bill for services that are part of a retraining plan (registration fees or supplies) that might be purchased prior to the plan.

Code	Description	Maximum Fee
0388R	Plan development services, nonvocational providers	By report

Vocational Evaluation and Related Codes for Nonvocational Providers

Certain nonvocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation, 1 unit = 6 minutes	$ 10.66
0390R	Work Evaluation, 1 unit = 6 minutes	$ 8.77
0391R	Travel/Wait (non-VRC), 1 unit = 6 minutes	$ 4.83
0392R	Mileage (non-VRC), one unit = 1 mile	State rate
0393R	Ferry Charges (non-VRC)(1)	State rate

(1) Requires documentation with a receipt in the case file.

A provider can use the **R** codes if he or she is a:

- Nonvocational provider such as an occupational or physical therapist or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider account number than you), you cannot bill as a vocational provider (provider type 68). You must either use another provider account number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider account number (type 97) and bill the appropriate codes for those services.

  NOTE: These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

  - The vocational referral ID that can be obtained from the assigned vocational provider and
  - The service provider ID for the assigned vocational provider in the "Name of physician or other referring source" box at the top of the form and
  - Nonvocational providers own provider account numbers at the bottom of the form.

TRAVEL/MILEAGE BILLING

The department pays for work performed by providers on vocational referrals only from the branch office where the referral was assigned. The department **does not pay** for travel time between two different service locations or branch offices where a provider is working cases. Providers should bill from the branch office where the referral has been received by the VRC to the necessary destinations, such as the following: going to the location of the employer of record, visiting an attending physician's office and the meeting of a VRC with an injured worker at his or her home.

FEE CAPS

Vocational services are subject to fee caps. These fee caps are hard caps, with no exceptions. The following fee caps are by referral. All services provided for the referral are included in the cap. Travel, wait time and mileage charges are not included in the fee cap for any referral type.

Description	Applicable Codes	Maximum Fee
Early Intervention Referral Cap, per referral	0800V, 0801V	$1,801.00
Assessment Referral Cap, per referral	0810V, 0811V	$3,003.00
Plan Development Referral Cap, per referral	0830V, 0831V	$6,014.00
Plan Implementation Referral Cap, per referral	0840V, 0841V	$5,680.00
Stand Alone Job Analysis Referral Cap, per referral	0808V, 0809V, 0378R	$ 459.00

The fee cap for work evaluation services applies to multiple referral types.

Description	Applicable Codes	Maximum Fee
Work Evaluation Services Cap	0821V, 0390R	$1,316.00

For example, if $698 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only $500 is available for payment under another referral type.

Early Intervention Fee Cap Extension

For early intervention referrals, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **1 time only per claim** and does not create a new referral.

The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills.

The claim manager must authorize the extension. No other early intervention professional services (for example, services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.

Description	Applicable Codes	Maximum Fee
Extension of Early Intervention Referral Cap, once per claim	0802V, 0803V	$ 1,756.00

ADDITIONAL REQUIREMENTS

Vocational Evaluation

Vocational evaluation is a counseling tool used to identify a worker's vocational aptitudes, skills, interests and abilities.

Vocational evaluation can be used during an assessment referral to help determine a worker's ability to benefit from vocational services when a recommendation of eligibility is under consideration. Vocational evaluation may also be used during a plan development referral to assist a worker in identifying a viable vocational goal. Vocational evaluation may include:

- Psychometric testing
- Interest testing
- Work samples
- Academic achievement testing
- Situational assessment
- Specific and general aptitude and skill testing

When a vocational rehabilitation provider obtains a vocational evaluation, the provider must ensure that the test administration, interpretation and reporting of results are performed in a manner consistent with assessment industry standards.

Vocational providers, provider type 68, must use procedure code 0821V to bill for work evaluation services.

Non-vocational provider types 97, 76, 34, 52, or 55 must use procedure code 0390R and bill using the miscellaneous billing form and include the:

- Vocational referral ID obtained from the assigned vocational provider, and
- Service provider ID for the assigned vocational provider in the "Name of the physician or other referring source" box at the top, and
- Non-vocational providers own provider account numbers at the bottom of the form.

For example, a school, provider type 76, receives a referral from a VRC for basic achievement testing. After administering the testing, the school must:

- Use the miscellaneous billing form and
- Obtain the vocational referral ID number from the VRC and place on the billing form and
- Obtain the VRC's service provider number and place in the "Name of the physician or other referring source" box at the top, and
- Place the school's provider account number at the bottom of the form.

Referrals that Reach the Fee Cap

Fee cap requirements

- The vocational provider must track costs associated with their referrals to assure the fee cap is not exceeded
- When a fee cap is reached, vocational providers are **not required** to continue to provide services over and above the fee cap without payment. However, providers must notify the claim manager of the situation.
- Providers must comply with all requirements in WAC Chapter 296-19A with regard to closing referrals, including submitting a closing report, even if the claim manager has closed the referral

Referral and fee cap considerations

- It is inappropriate for the vocational provider to recommend the claim manager close a referral to avoid reaching the fee cap. Providers must continue to deliver services as required by WAC Chapter 296-19A until the cap is reached.
- After closing a referral due to reaching a fee cap, it is not appropriate to suggest the claim manager refer the claim back to the same vocational counselor

How Multiple Providers Who Work on a Single Referral Bill for Services

Multiple providers may deliver services on a single referral if they have the **same** payee provider account number. This situation might occur when interns assist on referrals assigned to counselors, or where 1 provider covers the caseload of an ill provider. When more than 1 provider works on a referral, each provider must bill separately for services delivered on the referral; and each provider must use:

- His/her individual provider account number,
- The payee provider account number and
- The referral ID.

If several providers work on a single referral, the assigned provider is ultimately responsible for the referral. The performance data associated with that referral accrues to the **assigned** provider's performance rating.

Split Billing Across Multiple Referrals

When a worker has 2 or more open time-loss claims, L&I may make a separate referral for each claim. In cases where L&I makes 2 (or more) concurrent referrals for vocational services, L&I will specify if the vocational provider is to split the billing.

When billing for vocational rehabilitation services on multiple referrals and/or claims, follow these instructions:

1. Split billable hours over a larger interval of work (up to the entire billing date span), rather than per each single activity.

   Example: Provider XYZ has 2 open referrals for the same worker. If the provider bills once a week, one approach would be to total all the work done with that worker on both referrals in a day, or in the entire week, then divide by 2.
2. Bills must be split equally, in whole units, charging the same dollar amount on each claim/referral.
3. If, after totaling all work done during the billing period, the total is still not an even number of units, round to the nearest even whole number of units, then divide by 2 as directed above.
4. If split bills do not contain the same number of units, they will be denied and must be rebilled in the correct format.

If there are 3 (or more) claims requiring time-loss compensation and vocational services, the vocational rehabilitation bills are to be split accordingly (3 claims = by thirds, 4 claims = by fourths), based on the number of concurrent referrals received.

Vocational providers must document multiple referrals and split billing for audit purposes.

Referral Resolution

A vocational referral initially made to a firm, and then assigned to a VRC must close if the same VRC is no longer available to provide services. Referrals made directly to the VRC may be transferred by the claim manager to the VRC's new firm, only if the VRC has already *established a relationship with a new firm within the same service location*, via the Vocational Provider Account Application process.

Vocational providers **must** notify L&I if the VRC assigned to a referral is no longer available to provide services on that referral. Following are guidelines for notifying L&I:

Example 1:

For referrals made to the firm and assigned to a VRC:

- It is the responsibility of the assigned VRC to close the referral on Voc Link Connect with the outcome, "VRC no longer available". This outcome must be entered immediately upon the VRC's change in status.
- It is the responsibility of the vocational manager of the firm to notify L&I's claim manager(s) of the change in status for that referral. L&I must be notified by telephone and/or FAX within 3 working days of the change in status. Notification by the vocational manager is not necessary if the VRC assigned to the referrals successfully closes the referral as noted above.

The VRC assigned to the referral(s) **may not** contact the claim manager(s) for the purpose of informing them of a change in employment. This would be considered marketing, which is prohibited by L&I policy. The resolution (for example, re-referral) of the referral is at the sole discretion of the claim manager.

Example 2:

For referrals made directly to the VRC:

- The VRC is responsible for notifying the claim manager of his/her new status, and should be prepared to inform the claim manager of the payee provider account number of the new firm, as well as the VRC's new service provider account number associated with that firm
- The claim manager, at his/her sole discretion, may transfer the referral(s) to the VRC at the new firm, provided that the VRC is available to work in the same service location in which the original referral was made

Appropriate Timing of *VocLink Connect* Outcome Recommendations

L&I has established clear expectations regarding the submission of closing reports at the conclusion of a vocational referral.

Vocational providers use *VocLink Connect* to enter an outcome recommendation at the conclusion of work on a referral, The VRC must complete the report before a *VocLink* outcome recommendation is made to L&I. The paper report should be submitted to L&I at the same time that the outcome recommendation is made. The report is considered part of the referral, which is not complete until the report is done.

There are some circumstances when an outcome recommendation is made, and no report is required. Examples include "VRC no longer available" and "VRC declines referral".

In all other cases, the paper report must be submitted to L&I at the same time the recommendation is made.

Responsibilities of Service Providers and Firms in Regard to Changes in Status

L&I must be notified immediately by both the firm and the service provider (VRC or intern) when there is a change in status. Changes in status include:

- VRC or intern ends their association with a firm. VRC assigned to a referral is no longer available to provide services on the referral(s).
- Firm closes.

Notification to L&I requires:

1. Resolution of the open referral(s) and
2. Submission of the Vocational Provider Change Form(s) to Private Sector Rehabilitation Services (L&I, PO Box 44326, Olympia WA 98504-4326).

These forms may be found at L&I's vocational services web site http://www.lni.wa.gov/ClaimsIns/Providers/Vocational/Become/default.asp.

A firm or service provider that fails to notify L&I of changes in status may be in violation of Washington Administrative Code (WAC) and/or L&I policy. This may result in L&I issuing findings and subsequent corrective action(s) as described in WAC 296-19A-260 and WAC 296-19A-270.

Approved Plan Services that Occur Prior to the Plan Start Date

The following are services/fees that L&I may cover prior to a plan start date and outlines the procedure for adjudicating bills for dates of service prior to a plan start date.

- Registration fees billed as Retraining tuition, R0310
- Rent, food, utilities and furniture rental (Payment for these items may be made up to 29 days prior to a plan start date to allow a worker to move and get settled before training starts)

These services require **prior authorization** by the claims manager.

Bills for services incurred prior to a plan start date will not be paid prior to the date L&I formally approves the plan.

Retraining travel, R0330, is **not payable** prior to a plan start date. Travel that occurs prior to a plan start date is generally to a jobsite to evaluate whether a particular job goal is reasonable, or to a school to pay for registration, books or look over the campus. These types of trips are not part of a retraining plan and should be billed by the worker under V0028. Travel to appointments with the VRC should also be billed under V0028.

Selected Plan Procedure Code Definitions

L&I has defined the following retraining codes:

- R0312 Retraining supplies are consumable goods such as:
  - Paper
  - Pens
  - CDs
  - Disposable gloves
- R0315 Retraining equipment, tools such as:
  - Calculator
  - Software
  - Survey equipment
  - Welding gloves & hood
  - Bicycle repair kits
  - Mechanics tools
- R0350 Other, includes professional uniforms, including uniform shoes, required for training, and other items that don't fit the more defined categories. Items purchased using R0350 must be for vocational rehabilitation retraining.

L&I does not have the authority to purchase glasses, hearing aids, dental work, clothes for interviews, or other items as a way to remove barriers during retraining.

Reimbursement for Food

L&I reimburses for food including grocery and restaurant purchases made while the worker is participating in an approved plan.

The vocational provider must review charges for these expenses for inappropriate items (for example, personal items, alcohol, paper and cleaning products, tobacco, pet food, etc.) and to ensure each date of purchase is itemized on the bill. Charges for food, combined in weekly or monthly date spans, **are not allowed**. Each food purchase must be listed on a separate bill line for each date food is purchased. Receipts are always required for any item(s) purchased by the worker. Copies of receipts are acceptable. The provider and/or the worker should also retain a copy of receipts.

The worker may not request reimbursement over the monthly-allowed per diem amount. It is the vocational provider's responsibility to monitor the bills to ensure the worker does not exceed their monthly allotment for food.

The vocational provider will review the receipts, deduct personal and other noncovered items and sign the Statement for Retraining and Job Modification Services form.

Once the vocational provider signs the Statement for Retraining and Job Modification Services form L&I will assume the provider has reviewed the bill and receipts, removed inappropriate charges and has verified the charges are within the worker's per diem allotment for that month.

Mileage on Transportation Cost Encumbrance

L&I reimburses mileage only in whole miles. Calculate mileage point to point, rounding each planned trip up to the nearest whole mile.

Questions regarding completion of the Transportation Cost Encumbrance form should be referred to the unit Vocational Services Consultant.

Services Payable During a Plan Interruption

Some expenses related to retraining plans can be paid during a period of plan interruption. This generally occurs during the break between either the spring and fall quarters or summer and fall quarters. L&I may continue to pay rent and utility expenses for a second residence during an approved plan interruption. Books and supplies that are required for the following school term could also be paid during a plan interruption if the worker purchases these prior to the start of that term.

Under no circumstances will L&I cover transportation costs or childcare during periods of plan interruption. If a worker travels to keep appointments with his or her counselor, bill mileage on a separate travel voucher for retraining travel using the vocational travel code, V0028.

Facility Services

This section contains payment policies and information for facility services.

All providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules* (MARFS), Provider Bulletins and Provider Updates.

If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with MARFS, L&I's rules and policies take precedence

(see WAC 296-20-010).

All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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HOSPITAL PAYMENT POLICIES

HOSPITAL PAYMENT POLICIES OVERVIEW

Insurers will pay for the costs of proper and necessary hospital services associated with an accepted industrial injury. Hospital payment policies established by L&I are reflected in Chapters 296-20, 296-21, 296-23 and 296-23A WAC and in the Hospital Billing Instructions. No copayments or deductibles are required or allowed from workers.

HOSPITAL BILLING REQUIREMENTS

All charges for hospital inpatient and outpatient services provided to workers must be submitted on the UB-04 billing form using the UB-04 National Uniform Billing Committee Data Element Specifications. Hospitals are responsible for establishing criteria to define inpatient and outpatient services. For State Fund claims, inpatient bills will be evaluated according to L&I's Utilization Review Program. Inpatient bills submitted to L&I without a treatment authorization number may be selected for retrospective review. For observation services, L&I will follow CMS guidance. For a current copy of the Hospital Billing Instructions, contact the L&I Provider Hotline at 1-800-848-0811.

HOSPITAL ACQUISITION COST

Any item covered under the acquisition cost policy will be paid using a hospital specific percent of allowed charges (POAC). Non-hospital facilities will be paid a statewide average POAC.

HOSPITAL INPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital inpatient care provided to workers covered by Self-insurers are paid using hospital specific POAC factors for all hospitals (see WAC 296-23A-0210).

Crime Victims Compensation Program Payment Method

Services for hospital inpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using DSHS POAC factors (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital inpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. An All Patient Diagnosis Related Group (AP DRG) system. See WAC 296-23A-0470 for exclusions and exceptions. L&I currently uses AP DRG Grouper version 23.0.
2. A statewide per diem rate for those AP DRGs that have low volume or for inpatient services provided in Washington rural hospitals.
3. A POAC for hospitals excluded from the AP DRG system.

The following tables provide a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Inpatient Services
Hospitals not in Washington	Paid by an out-of-state POAC factor. Effective **July 1, 2008** the rate is **55.9%.**
Washington excluded Hospitals: • Children's Hospitals • Health Maintenance Organizations (HMOs) • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges.
• Washington Major Teaching Hospitals; • Harborview Medical Center • University of Washington Medical Center	Paid on a per case basis for admissions falling within designated AP DRGs.(1) For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical
All other Washington Hospitals	Paid on a per case basis for admissions falling within designated AP DRGs.(1) For low volume AP DRGs, Washington hospitals are paid using the statewide per diem rates for designated AP DRG categories: • Chemical dependency • Psychiatric • Rehabilitation • Medical • Surgical

(1) See http://feeschedules.LNI.wa.gov for the current AP DRG Assignment List.

Hospital Inpatient AP DRG Base Rates

Effective **July 1, 2008** the AP DRG Base Rates

Hospital	Base Rate
Harborview Medical Center	$11,889.12
University of Washington Medical Center	$10,459.28
All Other Washington Hospitals	$9,941.41

Hospital Inpatient AP DRG Per Diem Rates

Effective **July 1, 2008** the AP DRG per diem Rates are as follows:

Payment Category	Rate(1)	Definition
Psychiatric AP DRG Per Diem	**$842.33** Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs 424-432
Chemical Dependency AP DRG Per Diem	**$743.17** Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs 743-751
Rehabilitation AP DRG Per Diem	**$1,437.62** Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRG 462
Medical AP DRG Per Diem	**$1,997.06** Multiplied by the number of days allowed by L&I. Payment will not exceed allowed billed charges.	AP DRGs identified as medical
Surgical AP DRG Per Diem	**$3,849.68** Multiplied by the number of days allowed by L&I . Payment will not exceed allowed billed charges.	AP DRGs identified as surgical

(1) For information on how specific rates are determined see Chapter 296-23A WAC The AP DRG Assignment List with AP DRG codes and descriptions and length of stay is in the fee schedules section and is available online at http://feeschedules.LNI.wa.gov.

Additional Inpatient Hospital Rates

Payment Category	Rate	Definition
Transfer-out Cases	Unless the transferring hospital's charges qualify for low outlier status, the stay at this hospital is compared to the AP DRGs average length of stay. If the patient's stay is less than the average length of stay, a per-day rate is established by dividing the AP DRG payment amount by the average length of stay for the AP DRG. Payment for the first day of service is 2 times the per-day rate. For subsequent allowed days, the basic per-day rate will be paid. If the patient's stay is equal to or greater than the average length of stay, the AP DRG payment amount will be paid.	A transfer is defined as an admission to another acute care hospital within 7 days of a previous discharge.
Low Outlier Cases (costs are less than the threshold)	Hospital Specific POAC Factor multiplied by allowed billed charges.	Cases where the cost (1) of the stay is less than 10% of the statewide AP DRG rate or **$537.42**, whichever is greater.
High Outlier Cases (costs are greater than the threshold)	AP DRG payment rate plus 100% of costs in excess of the threshold.	Cases where the cost (1) of the stay exceeds **$16,236.19** or 2 standard deviations above the statewide AP DRG rate, whichever is greater.

(1) Costs are determined by multiplying the allowed billed charges by the hospital specific POAC factor.

HOSPITAL OUTPATIENT PAYMENT INFORMATION

Self-insured Payment Method

Services for hospital outpatient care provided to workers covered by Self-insurers are paid using facility-specific POAC factors or the appropriate Professional Services Fee Schedule amounts (see WAC 296-23A-0221).

Crime Victims Compensation Program Payment Method

Services for hospital outpatient care provided to crime victims covered by the Crime Victims Compensation Program are paid using either DSHS POAC factors or the Professional Services Fee Schedule (see WAC 296-30-090).

State Fund Payment Methods

Services for hospital outpatient care provided to workers covered by the State Fund are paid using 3 payment methods:

1. Outpatient Prospective Payment System (OPPS) using an Ambulatory Payment Classification (APC) system. See Chapter 296-23A WAC (Section 4), WACs 296-23A-0220, 296-23A-0700 through 296-23A-0780 for a description of L&I's OPPS system.
2. An amount established through L&I's Professional Services Fee Schedule for items not covered by the APC system
3. POAC for hospital outpatient services not paid by either the APC system or with an amount from the Professional Services Fee Schedule

The following table provides a summary of how the above methods are applied.

Hospital Type or Location	Payment Method for Hospital Outpatient Services
Hospitals not in Washington State	Paid by an out-of-state POAC factor. Effective **July 1, 2008** the rate is **55.9%.**
Washington Excluded Hospitals: • Children's Hospitals • Military Hospitals • Veterans Administration • State Psychiatric Facilities	Paid 100% of allowed charges
• Rehabilitation Hospitals • Cancer Hospitals • Critical Access Hospitals • Private Psychiatric Facilities	Paid a facility-specific POAC or Fee Schedule amount depending on procedure
All other Washington Hospitals	Paid on a per APC (1) basis for services falling within designated APCs. For non-APC paid services, Washington hospitals are paid using an appropriate Professional Services Fee Schedule amount, or a facility-specific POAC(1).

(1) Hospitals will be sent their individual POAC and APC rate each year.

Pass-Through Devices

A transitional pass-through device is an item accepted for payment as a new, innovative medical device by CMS where the cost of the new device has not already been incorporated into an APC. Hospitals will be paid fee schedule or if no fee schedule exists, a hospital-specific POAC for new or current pass-through devices. New or current drug or biological pass-through items will be paid by fee schedule or POAC (if no fee schedule exists).

Hospital OPPS Payment Process

Question	Answer	Payment Method
1. Does L&I cover the service?	No	Do Not Pay
	Yes	Go to question 2
2. Does the service coding pass the Outpatient Code Editor (OCE) edits?	No	Do Not Pay
	Yes	Go to question 3
3. Is the procedure on the inpatient-only list?	No	Go to question 4
	Yes	Pay POAC(1)
4. Is the service packaged?	No	Go to question 5
	Yes	Do Not Pay, but total the Costs for possible outlier(2) consideration. Go to question 7.
5. Is there a valid APC?	No	Go to question 6
	Yes	Pay the APC amount and total payments for outlier(2) consideration. Go to question 7.
6. Is the service listed in a Fee Schedule?	No	Pay POAC
	Yes	Pay the Facility Amount for the service
7. Does the service qualify for outlier?(1)	No	No outlier payment
	Yes	Pay outlier amount (3)

(1) If only 1 line item on the bill is IP, the entire bill will be paid POAC.
(2) Only services packaged or paid by APC are used to determine outlier payments.
(3) Outlier amount is in addition to regular APC payments.

OPPS Relative Weights and Payment Rates

The relative weights used by CMS will be used for the OPPS program. Each hospital's blended per-APC rate was determined using a combination of the average hospital-specific per APC rate and the statewide average per APC rate. Additional information on the formulas used to establish individual hospital rates can be found in WAC 296-23A-0720. Hospitals will receive notification of their blended per-APC rate via separate letter from L&I or by accessing http://feeschedules.LNI.wa.gov and going to the hospital rates link.

OPPS Outlier Payments

L&I follows the current CMS outlier payment policy. See the most current federal register for a complete description of the policy.

AMBULATORY SURGERY CENTER PAYMENT POLICIES

GENERAL INFORMATION

Information about L&I's ambulatory surgery center (ASC) requirements can be found in Chapter 296-23B WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state does not require licensure;
2. Must have at least 1 of the following credentials:
    a. Medicare Certification as an ambulatory surgery center or
    b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicare Services (CMS) and
3. Must have an active ASC provider account with L&I.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities
5101 Washington Street, Suite #2F
PO BOX 9500 Gurnee, IL 60031
888-545-5222; www.aaaasf.org/

Accreditation Association for Ambulatory Health Care
3201 Old Glenview Rd., Suite 300
Wilmette, IL 60091
847-853-6060; www.aaahc.org/

American Osteopathic Association
142 East Ontario Street
Chicago, IL 60611
800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities
4891 East Grant Road
Tucson, AZ 85712
888-281-6531; http://www.carf.org/

Joint Commission on Accreditation of Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
630-792-5862; www.jcaho.org/

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or L&I's maximum allowed rate.

L&I's rates are based on a modified version of the current system developed by Medicare for ASC services.

ASC Procedures Covered for Payment

L&I uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed online at: http://feeschedules.LNI.wa.gov

L&I expanded the list that CMS established for allowed procedures in an ASC. L&I added some procedures CMS identified as excluded procedures.

ASC Procedures Not Covered for Payment

Procedures not listed in the ASC fee schedule section of MARFS are not covered in an ASC.

ASCs will not receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Noncovered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on L&I's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain:

- A description of the proposed procedure with associated CPT® or HCPCS procedure codes,
- The reason for the request,
- The potential risks and expected benefits and
- The estimated cost of the procedure.

The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Affecting Payment for ASCs

–50 Bilateral Procedure

Modifier –50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

–51 Multiple Procedures

Modifier –51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier –51 should be applied to the second line item. The total payment equals the sum of:

> **100%** of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus
> **50%** of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

–52 Reduced Services

Modifier –52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier –52, signifying that the service is reduced.

Beginning July 1, 2008 a **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that do not require anesthesia (ASCs should use modifier –52 to report such an occurrence).

–73 Discontinued procedures prior to the administration of anesthesia

Modifier –73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–74 Discontinued procedures after administration of anesthesia

Modifier –74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–99 Multiple modifiers

Modifier –99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier –99 must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

BRAIN INJURY REHABILITATION SERVICES

QUALIFYING PROVIDERS

Only providers accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) may participate in the Brain Injury Program and provide post-acute brain injury rehabilitation services for workers. When a complete course of evaluation and treatment is required, L&I requires providers treating a patient on a State Fund claim to submit proof of CARF accreditation to

Department of Labor & Industries
Provider Accounts Unit
PO Box 44261
Olympia, WA 98504-4261

Billing for Separate Services and Therapies

Brain injury and rehabilitation services are currently under review. Until that review is complete and **upon approval** by an ONC, individual services and therapies can be done separately through outpatient services when the attending physician submits a coordinated plan of care. Services can include but are not limited to:

- Psychotherapy services
- Speech therapy
- Language therapy
- Physical therapy
- Occupational therapy

Special L&I Provider Account Number Required

Providers participating in the Brain Injury Program must have a special provider account number for their CARF accredited post-acute brain injury rehabilitation program in order to bill L&I for a complete course of evaluation and treatment. Providers may request a provider application or find out if they have a qualifying provider account number by calling the Provider Hotline at 1-800-848-0811.

NOTE: Providers participating in the Brain Injury Program and billing for State Fund claims for a complete course of evaluation and treatment must bill brain injury rehabilitation services using the special post-acute brain injury rehabilitation program provider account number assigned by L&I. Providers billing for individual services and therapies do not need to obtain a special provider account number.

QUALIFYING PROGRAMS

Post-acute brain injury rehabilitation programs must include the following phases:

- Evaluation
- Treatment
- Follow-up

AUTHORIZATION REQUIREMENTS

Prior authorization is required for post-acute brain injury rehabilitation evaluation and treatment. State Fund cases requiring post-acute brain injury rehabilitation will be reviewed by the ONCs prior to making a determination or authorization. Call the Provider Hotline at 1-800-848-0811 for authorization.

After an ONC reviews the case the L&I claims manager also needs to review for **prior authorization**.

Approval Criteria

Before a worker can receive treatment all of the following conditions must be met:

- The insurer has allowed brain injury as an accepted condition under the claim; and
- The brain injury is related to the industrial injury or is retarding recovery; and
- The worker is physically, emotionally, cognitively and psychologically capable of full participation in the rehabilitation program; and
- The screening evaluation done by the brain injury program demonstrates the worker is capable of new learning following the brain injury; and
- The screening evaluation report by the program identifies specific goals to help the worker improve function or accommodate for lost function.

Comprehensive Brain Injury Evaluation Requirements

A Comprehensive Brain Injury Evaluation must be performed for all workers who are being considered for inpatient services or into an outpatient post-acute brain injury rehabilitation treatment program. This evaluation is multidisciplinary and contains an in-depth analysis of the workers mental, emotional, social and physical status and functioning.

The evaluation must be provided by a multidisciplinary team that includes a

- Medical physician,
- Psychologist,
- Vocational rehabilitation specialist,
- Physical therapist,
- Occupational therapist,
- Speech therapist and
- Neuropsychologist.

Additional medical consultations are referred through the program's physician. Each consultation may be billed under the provider account number of the consulting physician and must be preauthorized by an L&I ONC.

BILLING INFORMATION

Tests Included in the Comprehensive Brain Injury Program Evaluation

The following tests and services are included in the price of performing a Comprehensive Brain Injury Program Evaluation and **may not be billed separately**. They may be performed in any combination depending on the workers condition

- Neuropsychological Diagnostic Interview(s), testing and scoring
- Initial consultation and exam with the programs physician
- Occupational and Physical Therapy evaluations
- Vocational Rehabilitation evaluation
- Speech and language evaluation
- Comprehensive report

Preparatory Work Included in the Comprehensive Brain Injury Program Evaluation

The complementary and/or preparatory work that may be necessary to complete the Comprehensive Brain Injury Evaluation is considered part of the provider's administrative overhead. It includes but is not limited to:

- Obtaining and reviewing the workers historical medical records
- Interviewing family members, if applicable
- Phone contact and letters to other providers or community support services
- Writing the final report
- Office supplies and materials required for service(s) delivery

Therapies Included in the Treatment

The following therapies, treatments and/or services are included in the Brain Injury Program maximum fee schedule amount for the full-day or half-day brain injury rehabilitation treatment and **may not be billed separately:**

- Physical therapy and occupational therapy
- Speech and language therapy
- Psychotherapy
- Behavioral modification and counseling
- Nursing and health education and pharmacology management
- Group therapy counseling
- Activities of daily living management
- Recreational therapy (including group outings)
- Vocational counseling
- Follow-up interviews with the worker or family, which may include home visits and phone contacts

Preparatory Work Included in Treatment

Ancillary work, materials and preparation that may be necessary to carry out Brain Injury Program functions and services that are considered part of the provider's administrative overhead and are **not payable separately** include, but are not limited to:

- Daily charting of patient progress and attendance
- Report preparation
- Case management services
- Coordination of care
- Team conferences and interdisciplinary staffing
- Educational materials (for example, workbooks and tapes)

Follow Up Included in Treatment

Follow up care is included in the cost of the full day or half day program. This includes, but is not limited to:

- Telephone calls
- Home visits
- Therapy assessments

DOCUMENTATION REQUIREMENTS

The following documentation is required of providers when billing L&I for post-acute brain injury rehabilitation treatment programs:

- Providers are required to keep a daily record of a workers attendance, activities, treatments and progress
- All test results and scoring must also be kept in the workers medical record. Records should also include:
  - Documentation of interviews with family and
  - Any coordination of care contacts (for example, phone calls and letters) made with providers or case managers not directly associated with the facility's program
- Progress reports should be sent to L&I regularly, including all preadmission and discharge reports

FEES

Non-Hospital Based Programs

The following are the local codes and payment amounts for nonhospital based outpatient post-acute brain injury rehabilitation treatment programs.

Code	Description	Maximum Fee
8950H	Comprehensive brain injury evaluation	$4,156.22
8951H	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	$942.81
8952H	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	$565.64

Hospital Based Programs

The following are the revenue codes and payment amounts for hospital based outpatient post-acute brain injury rehabilitation treatment programs.

Code	Description	Maximum Fee
0014	Comprehensive brain injury evaluation	$4,156.22
0015	Post-acute brain injury rehabilitation full-day program, per day (minimum of 6 hours per day)	$942.81
0016	Post-acute brain injury rehabilitation half-day program, per day (minimum 4 hours per day)	$565.64

NURSING HOME, RESIDENTIAL AND HOSPICE CARE SERVICES

COVERED SERVICES

The insurer covers proper and necessary residential care services that require 24-hour institutional care to meet the workers needs, abilities and safety. The insurer will also cover medically necessary hospice care comprising of skilled nursing care and custodial care for the workers accepted industrial injury or illness.

Prior authorization is required by an L&I ONC or the self-insured employer.

Services must be:

- Proper and necessary and
- Required due to an industrial injury or occupational disease and
- Requested by the attending physician and
- Authorized by an L&I ONC before care begins.

Facilities

Qualifying providers are DSHS licensed or certified facilities providing residential services for 24-hour institutional care including:

- Skilled Nursing Facilities (SNF)
- Nursing Homes (NH)
- Transitional Care Units (TCU) that are independent and licensed by DOH or who are doing business as part of a Nursing Home or Hospital and are **covered** by the license of the Nursing Home or Hospital
- Adult Family Homes
- Boarding Homes
- Hospice care providers

For industrial injury claims, providers must have the staff and equipment available to meet the needs of the workers.

NONCOVERED SERVICES

Services in assisted living facilities and adult day care centers are **not covered** by L&I or by self insurers.

AUTHORIZATION REQUIREMENTS

Initial Admission

Residential care services require **prior authorization**. To receive payment, providers must notify the insurer when they agree to provide residential care services for a worker.

Only an L&I ONC can authorize residential care services for L&I claims. The ONC authorizes an initial length of stay based on discussions with the facility's admissions coordinator. Call the Provider Hotline at 1-800-848-0811 for authorization.

For authorization procedures on a self-insured claim, contact the self-insurer directly.

Nursing facilities and transitional care units must complete the most current version of the Minimum Data Set (MDS) Basic Assessment Tracking Form for the worker within 10 working days of admission. The form is available from CMS at http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp#TopOfPage

This form or similar instrument will also determine the appropriate L&I payment group. The same schedule as required by Medicare should be followed when performing the MDS reviews.

Failure to assess the worker or report the appropriate payment group to an L&I ONC may result in delayed or reduced payment. This requirement applies to all lengths of stay.

L&I has a form available that can be substituted for the MDS form. The Resource Utilization Group (RUG) Residential Care Services for L&I injured Workers form F245-052-000 is available at

http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1623

When Care Needs Change

State Fund

If the needs of the worker change, a new assessment must be completed and communicated to an L&I ONC.

If the initial length of stay needs to be extended, or if the severity of the workers condition changes, contact an L&I ONC for re-authorization of the workers care.

Self-Insured

Contact the self-insurer directly for policies regarding changes in the care needs of self-insured claims.

BILLING INFORMATION

Billing Requirements

State Fund

Providers beginning treatment on an L&I claim on or after January 1, 2005 will use the fee schedule or new daily rates appropriate for the type of facility providing treatment and must meet other requirements outlined in this section.

The primary billing procedures for L&I claims applicable to residential facility providers can be found in WAC 296-20-125, Billing procedures.

All L&I Residential Care Services should be billed on form F245-072-000 Statement for Miscellaneous Services found at http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1627

Self-Insured

Contact the self-insurer directly for billing, payment, documentation and record keeping requirements about self-insured claims.

Pharmaceuticals and Durable Medical Equipment

State Fund

Residential facilities cannot bill for pharmaceuticals or DME on L&I claims. Pharmaceuticals and DME required to treat the worker's accepted condition must be billed separately.

Self-Insured

Contact the self-insurer for pharmaceutical and DME billing procedures on self-insured claims.

Inappropriate use of CPT® and HCPCS codes may delay payment. For example, billing drugs or physical therapy using DME codes is improper coding and will delay payment while being investigated.

L&I REVIEW OF RESIDENTIAL SERVICES

State Fund

L&I or its designee may perform periodic independent nursing evaluations of residential care services provided to L&I workers. Evaluations may include, but are not limited to, on-site review of the worker and review of medical records.

All services rendered to workers for L&I claims are subject to audit by L&I. See RCW 51.36.100 and RCW 51.36.110.

Self-Insured

For review procedures on a self-insured claim, contact the self-insurer directly.

FEES

Negotiated payment arrangements; Self-insured and L&I claims with existing negotiated arrangements:

Code	Description	Maximum Fee
8902H	Negotiated payment arrangements	By report

NOTE: Providers with existing negotiated arrangements made prior to January 1, 2005 may continue their current arrangements and continue to use code 8902H until the worker's need for services no longer exists or the worker is transferred to a new facility.

Hospice Care

Hospice claims are paid on a By report basis. Occupational, physical and speech therapies are included in the daily rate and are not separately payable. Pharmacy and DME are payable when billed separately using appropriate HCPCS codes.

Programs must bill the following HCPCS codes:

Code	Abbreviated Description	Maximum Fee
Q5003	Hospice Care Prov in Nrsng Lng-Trm Care Facility	By report
Q5004	Hospice Care Prov in Skill Nursing Facility	By report
Q5005	Hospice Care Prov in Inpatient Hospital	By report
Q5006	Hospice Care Prov in Inpatient Hospice Facility	By report
Q5007	Hospice Care Prov in Lng Trm Care Facility	By report
Q5008	Hospice Care Prov in Inpatient Psychiatric Facility	By report
Q5009	Hospice Care Prov in Place NOS	By report

Boarding Homes and Adult Family Homes

State Fund

Billing codes and payment rates:

Code	Description	Maximum Fee
8891H	Adult family home residential care for workers (per day)	$228.04

Code	Description	Maximum Fee
8892H	Boarding home residential care for workers (per day)	$125.22

Self-insured

Self-insurers will negotiate rates. Contact the self-insurer directly.

Nursing Home and Transitional Care Unit Fees

State Fund

L&I uses a modified version of the skilled nursing facility prospective payment system for developing the residential facility payment system.

The fee schedule for NHs and TCUs is a series of daily facility payment rates including room rate, therapies and nursing components depending on the needs of the worker. Medications are not included in the L&I rate. The L&I rate applies to L&I claims only.

Fee Schedule – Nursing Homes & Transitional Care Units Effective 07/01/08

Code	Description	Included Medicare Rug Groups	Maximum Fee
		REHAB GROUPS	
8880H	Rehab-Ultra High	RUX, RUL, RUC, RUB, RUA	$629.54
8881H	Rehab-Very High	RVX, RVL, RVC, RVB, RVA	$471.98
8882H	Rehab-High	RMX, RHX, RHL, RHC, RHB, RHA	$445.07
8883H	Rehab-Medium	RML, RMC, RMB, RMA	$410.02
8884H	Rehab-Low	RLX, RLB, RLA	$320.06
		NURSING SERVICES GROUPS	
8885H	Extensive Services	SE3, SE2, SE1	$398.70
8886H	Special Care	SSC, SSB, SSA	$296.99
8887H	Clinically Complex	CC2, CC1, CB2, CB1, CA2, CA1	$295.37
8888H	Impaired Cognition	IB2, IB1, IA2, IA1	$217.88
8889H	Behavior Only	BB2, BB1, BA2, BA1	$216.26
		REDUCED PHYSICAL FUNCTION GROUPS	
8890H	Reduced Physical Function	PE2, PE1, PD2, PD1, PC2, PC1, PB2, PB1, PA2, PA1	$228.04

Self-insured

Self-insurers will negotiate rates. Contact the self-insurer directly.

CHRONIC PAIN MANAGEMENT PROGRAM

Eligibility Requirements

To provide chronic pain management program services to workers, the provider must be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The term interdisciplinary describes the type of program and not the practice skills of staff members. Providers of chronic pain management program services must work within the scope of practice for their specialty and/or be appropriately certified or licensed for the field in which they work.

Providers must maintain CARF accreditation and provide L&I with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed for administrative reasons.

When a CARF Accredited Provider is not Reasonably Available

In certain circumstances, a CARF accredited provider may not be reasonably available for workers who have moved out of Washington State. In those circumstances, a provider with CARF-like credentials may provide chronic pain management program services to the worker.

For outpatient services, these CARF-like credentials include:

- Patient prescreening is conducted by a physician, a psychiatrist/psychologist, and a physical/occupational therapist. Vocational rehabilitation may be added if the claim manager determines vocational assessment is needed.
- Regular interface occurs between a physician and the worker on a frequent, if not daily basis during treatment
- Treatment includes, at a minimum, medical management, psychiatric testing and/or counseling, physical and occupational therapy, and, if indicated, vocational rehabilitation services with return to work goals as indicated
- Follow-up includes remedial treatment or status checks to determine how well the worker is coping following completion of their treatment

For inpatient services, these CARF-like credentials include:

- The outpatient services credentials listed above and
- Affiliation with a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited hospital.

CARF-like providers will be required to comply with the chronic pain management program policies and fee schedule as well as meet the same reporting requirements as CARF accredited programs. CARF-like providers must also obtain an L&I provider account number. The provider account number for CARF-like providers will be activated for only 9 months.

When to Refer an Injured Worker for a Chronic Pain Management Evaluation

When the attending provider requests a referral to a chronic pain management program, the claim manager may authorize an evaluation if the worker has chronic pain, is not a surgical candidate and meets 1 of the following criteria:

- Has received conservative treatment for approximately 6 months:
  - without significant improvement,
  - has a perceived degree of pain, and
  - has not returned to work, or
- Has not significantly improved or has not returned to work due to pain within 6 months following authorized surgery or
- Has a significant pain medication abuse problem or
- Has returned to work but needs help with chronic pain management.

Chronic Pain Management Phases

A chronic pain management program has an interdisciplinary team that provides appropriate services to rehabilitate persons with chronic pain. Multiple modalities address the psychosocial and cognitive aspects of chronic pain behavior together with physical rehabilitation.

A chronic pain management program consists of three phases with a separate fee for each phase.

The chronic pain management program phases are defined as:

- Evaluation Phase
  - This phase consists of an initial evaluation including at a minimum a medical examination, and a psychological evaluation
  - A vocational assessment will be included in the initial evaluation if requested by the claim manager
  - A summary evaluation report is required and must include information from each discipline participating in the evaluation and a return to work action plan if indicated
  - This phase lasts 1 to 2 days
- Treatment Phase
  - At a minimum, this phase consists of medical management, psychiatric testing and/or counseling, and physical therapy/occupational therapy
  - Vocational rehabilitation services with return to work goals will be part of this phase if requested by the claim manager
  - Other services provided in this phase may vary as required by the need of the worker
  - A discharge report is required and must include the findings of each discipline involved in the treatment phase and must list the outcome of the treatment
  - The maximum duration of this phase is 18 treatment days. The 18 treatment days are consecutive (excluding weekends and holidays). Each treatment day lasts 6-8 hours.
- Follow Up Phase
  - This phase consists of remedial treatment or status checks as needed to determine how well the worker is coping following completion of the treatment phase. The goal is to extend and reinforce the gains made during the treatment phase. This phase is not a substitute for and cannot serve as a second treatment phase.
  - A follow up report is required including the findings of all disciplines involved in providing the follow up services
  - This phase will last for no more than a total of 5 follow up days during the 3 months immediately following completion of the treatment phase or treatment phase extension (information about the treatment phase extension is provided under the *Treatment Phase Extension Criteria* heading next in this subsection)

The reports required for each phase must be sent to the insurer and to the attending physician. When requested, other reports may be required.

The fee schedule and procedure codes for these phases are listed in the Fees section on page **178**. This fee schedule applies to workers in either an outpatient or inpatient program.

Treatment Phase Extension Criteria

The claim manager can authorize up to 10 additional days of treatment for the worker.

Before the claim manager authorizes the treatment phase extension, 1 or both of the following criteria must be documented in the extension request:

- Treatment is steadily progressing toward achievement of a treatment goal and how the extension supports the meeting of the specific treatment goal
- The worker is nearing completion of treatment and needs a few more sessions to achieve the treatment goal

The following factors will be applied when evaluating a request for extending treatment:

- The treatment phase extension is limited to a 1 time basis per referral
- The extension should be on an outpatient basis. Extension of inpatient services will require concurrence of an L&I ONC or self insurer based on their review of the extension request and claim file.
- Extensions are not granted for either the evaluation or follow up phases
- The extension is limited to a specific number of treatment days not to exceed a maximum of 10 consecutive treatment days (excluding weekends and holidays). The start and end dates must be defined prior to start of the treatment phase extension.
- The treatment phase extension request must be based on specific issues requiring further treatment. The request must be supported by documentation of progress made to date in the program.
- The request must clearly state the goals of the treatment phase extension and time needed to meet those goals

RETURN TO WORK ACTION PLAN

If the worker needs assistance in returning to work or becoming employable, the claim manager will authorize admission to the chronic pain management program for treatment after:

- A vocational counselor has been assigned by the claim manager
- The chronic pain management program vocational specialist (program counselor) and the insurer assigned vocational rehabilitation counselor have agreed upon a return to work action plan with a return to work goal acceptable to the insurer and
- The attending provider and the worker approve the return to work action plan with a return to work goal.

The return to work action plan is to provide the focus for vocational services during a workers' participation in a chronic pain management program. The insurer assigned vocational provider will facilitate the review, revision, and approval of the return to work action plan by the attending provider and the worker.

The return to work action plan may be modified or adjusted during the treatment or follow up phase as needed. At the end of the program the listed return to work action plan outcomes must be included with the treatment discharge report.

Return To Work Action Plan Roles And Responsibilities

In the development and implementation of the return to work action plan, the program counselor, the L&I assigned counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

1. The program counselor:
   - Co-develops the return to work action plan with the insurer assigned vocational provider
   - Presents the return to work action plan to the claim manager at the completion of the evaluation phase if the worker is recommended for admission for treatment and needs assistance with a return to work goal
   - Communicates with the insurer assigned vocational provider during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan
2. The insurer assigned vocational provider:
   - Co-develops the return to work action plan with the program counselor
   - Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone
   - Negotiates with the attending provider when the initial return to work action plan is not approved in order to resolve the attending provider's concerns
   - Obtains the workers' signature on the return to work action plan
   - Communicates with the program counselor during the treatment and follow-up phases to resolve any problems in implementing the return to work action plan
   - Implements the return to work action plan following the conclusion of the treatment phase
3. The attending provider:
   - Reviews and approves/disapproves the initial return to work action plan within 15 days of receipt
   - Reviews and signs the final return to work action plan at the conclusion of the treatment phase within 15 days of receipt
   - Communicates with the insurer assigned vocational provider during the treatment and follow-up phases to resolve any issues affecting the return to work goal
4. The worker:
   - Will participate in the selection of a return to work goal
   - Will review and sign the final return to work action plan
   - Will cooperate with all reasonable requests in developing and implementing the return to work action plan. Should the worker fail to be cooperative, the sanctions as set out in RCW 51.32.110 shall be applied.

FEES

Non-Hospital Based Programs

Outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	2010M	Conducted over 1-2 days	$1,106.63
Pain Clinic Treatment Phase	2011M	Not to exceed 18 treatment days	$708.82 per day
Pain Clinic Treatment Extension Phase	2012M	Not to exceed 10 treatment days	$708.82 per day
Pain Clinic Follow-Up Phase	2013M	Not to exceed 5 follow-up days	$304.69 per day

Hospital Based Programs

Facility based chronic pain management programs will bill using the revenue codes listed in the following table on a CMS-1450 (UB-04) form.

Description	Revenue Code	Duration	Fee Schedule
Pain Clinic Evaluation Phase	0011	Conducted over 1-2 days	$1,106.63
Pain Clinic Treatment Phase	0012	Not to exceed 18 treatment days	$708.82 per day
Pain Clinic Treatment Extension Phase	0017	Not to exceed 10 treatment days	$708.82 per day
Pain Clinic Follow-Up Phase	0013	Not to exceed 5 follow-up days	$304.69 per day

Inpatient Room And Board Fees

There are occasions when the chronic pain management program evaluation indicates a need for the worker to be treated on an inpatient basis. All inpatient admissions will require **prior authorization**. All State Fund inpatient admissions also require utilization review.

Utilization review for L&I is provided by Qualis Health. Eligible providers will contact Qualis Health at 1-800-541-2894 or fax their request to 1-877-665-0383. Qualis Health will compare the workers' clinical information to established criteria and make a recommendation to approve or deny the inpatient admission request to the claim manager.

For authorization procedures on a self insured claim, contact the self isurer directly.

The claim manager will make the final authorization decision. When the claim manager authorizes treatment on an inpatient basis, the provider will be paid up to $503.31 per day for room and board costs. These costs should be billed using either revenue code 0129 (semiprivate) or 0149 (private).

An acceptable return to work action plan is a one-page statement included with the chronic pain management program's vocational evaluation report that contains:

- The workers' current vocational status with the employer of injury
- The workers' current level of physical function
- The appropriate U.S. Department of Labor Dictionary of Occupational Titles (DOT) number and physical demands of the job goal common to the immediate labor market
- The actions, timelines, and people responsible for achieving the return to work action plan goal

BILLING FOR PARTIAL DAYS IN TREATMENT OR FOLLOW-UP PHASES

It is expected that the worker will attend the full 6-8 hours each treatment day during the treatment phase. If the worker is unable to complete a full day of treatment due to an emergency or unforeseen circumstance, the provider should bill for that portion of the treatment day completed by the worker.

> **Example 1:** Clinic A requires the worker to be in attendance for 8 hours for each treatment day. The worker had an unforeseen emergency and had to leave the clinic after 2 hours (25% of the treatment day) on one treatment day. The clinic would bill L&I for that day as follows: $708.82 x 25% = $177.21

For the follow up phase, the provider should bill for that portion of the follow up day that the worker is in attendance.

> **Example 2:** Clinic B scheduled the worker for 3 hours of follow-up services. Clinic B's normal hours of attendance for the worker is 6 hours. Clinic B would bill L&I for those 3 hours of follow-up services as follows: $304.69 x 50% = $152.35

Appendices

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APPENDIX A
ENDOSCOPY FAMILIES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Base	Family
29805	29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826 and 29828
29830	29834, 29835, 29836, 29837 and 29838
29840	29843, 29844, 29845, 29846 and 29847
29860	29861, 29862 and 29863
29870	29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886 and 29887
31505	31510, 31511, 31512 and 31513
31525	31527, 31528, 31529, 31530, 31535, 31540, 31560 and 31570
31526	31531, 31536, 31541, 31545, 31546, 31561 and 31571
31575	31576, 31577, 31578 and 31579
31622	31623, 31624, 31625, 31628, 31629, 31630, 31631, 31635, 31636, 31638, 31640, 31641, and 31645
43200	43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227 and 43228
43235	43231, 43232, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258 and 43259
43260	43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and 43272
44360	44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372 and 44373
44376	44377, 44378 and 44379
44388	44389, 44390, 44391, 44392, 44393, 44394 and 44397
45300	45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321 and 45327
45330	45331, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340 and 45345
45378	45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391 and 45392
46600	46604, 46606, 46608, 46610, 46611, 46612, 46614 and 46615
47552	47553, 47554, 47555 and 47556
49320	38570, 49321, 49322, 49323, 58541, 58550, 58660, 58661, 58662, 58670, 58671, 58672 and 58673
50551	50555, 50557 and 50561
50570	50572, 50574, 50575, 50576 and 50580
50951	50953, 50955, 50957 and 50961
50970	50974 and 50976
52000	52001, 52005, 52007, 52010, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52301, 52305, 52310, 52315, 52317,,52318, 52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343, 52344, 52400 and 52402
52351	52345, 52346, 52352, 52353, 52354 and 52355
57452	57454,57455, 57456, 57460 and 57461
58555	58558, 58559, 58560, 58561, 58562, 58563 and 58565

APPENDIX B
BUNDLED SERVICES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Bundled CPT® Code
15850
20930
20936
22841
78890
78891
90885
90887
90889
91123
92352
92353
92354
92355

Bundled CPT® Code
92358
92371
92531
92532
92533
92534
92605
92606
92613
92615
92617
93770
94150
94760

Bundled CPT® Code
94761
96545
97010
97605
97606
99000
99001
99002
99024
99051
99056
99058
99078
99090

Bundled CPT® Code
99091
99100
99116
99135
99140
99144
99145
99173
99358
99359
99374
99377
99379

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A9900	Supply/accessory/service
G0008	Admin influenza virus vac
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis b vaccine
Q3031	Collagen Skin Test
R0076	Transport portable EKG
V5010	Assessment for hearing aid
V5011	Fit/orientation/check of hearing aid
V5020	Conformity evaluation

APPENDIX C
BUNDLED SUPPLIES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT® or HCPCS book for complete coding information.

Items with an asterisk (*) are used as orthotics/prosthetics and may be paid separately for **permanent** conditions if they are provided in the physician's office. These items are not considered prosthetics if the condition is acute or temporary.

For example, Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions may be paid separately when provided in the physician's office. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthetic/orthotic and would be paid separately.

Surgical dressings and other items dispensed for home use are separately payable when billed with local modifier –1S.

Bundled CPT® Code
99070
99071

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A4206	1 CC sterile syringe & needle
A4207	2 CC sterile syringe & needle
A4208	3 CC sterile syringe & needle
A4209	5+ CC sterile syringe & needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4215	Sterile needle
A4216	Sterile water/saline, 10 ml
A4217	Sterile water/saline, 500 ml
A4218	Sterile saline or water
A4244	Alcohol or peroxide per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4248	Chlorhexidine antisept
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A4257	Replace Lensshield Cartridge
A4258	Lancet device each
A4259	Lancets per box
A4262	Temporary tear duct plug
A4263	Permanent tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML
A4306	Drug delivery system <=5 ML
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A4320	Irrigation tray
A4322	Irrigation syringe
A4326*	Male external catheter
A4327*	Fem urinary collect dev cup
A4328*	Fem urinary collect pouch
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335*	Incontinence supply
A4338*	Indwelling catheter latex
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4349	Disposable male external cat
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg bag
A4361*	Ostomy face plate
A4362*	Solid skin barrier
A4363	Ostomy clamp, replacement
A4364*	Ostomy/cath adhesive
A4365*	Ostomy adhesive remover wipe
A4366*	Ostomy vent
A4367*	Ostomy belt
A4368*	Ostomy filter
A4369*	Skin barrier liquid per oz
A4371*	Skin barrier powder per oz
A4372*	Skin barrier solid 4x4 equiv
A4373*	Skin barrier with flange
A4375*	Drainable plastic pch w fcpl
A4376*	Drainable rubber pch w fcplt
A4377*	Drainable plstic pch w/o fp
A4378*	Drainable rubber pch w/o fp
A4379*	Urinary plastic pouch w fcpl
A4380*	Urinary rubber pouch w fcplt
A4381*	Urinary plastic pouch w/o fp

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A4382*	Urinary hvy plstc pch w/o fp
A4383*	Urinary rubber pouch w/o fp
A4384*	Ostomy faceplt/silicone ring
A4385*	Ost skn barrier sld ext wear
A4387*	Ost clsd pouch w att st barr
A4388*	Drainable pch w ex wear barr
A4389*	Drainable pch w st wear barr
A4390*	Drainable pch ex wear convex
A4391*	Urinary pouch w ex wear barr
A4392*	Urinary pouch w st wear barr
A4393*	Urine pch w ex wear bar conv
A4394*	Ostomy pouch liq deodorant
A4395*	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402*	Lubricant per ounce
A4404*	Ostomy ring each
A4405*	Nonpectin based ostomy paste
A4406*	Pectin based ostomy paste
A4407*	Ext wear ost skn barr <=4sq"
A4408*	Ext wear ost skn barr >4sq"
A4409*	Ost skn barr w flng <=4 sq"
A4410*	Ost skn barr w flng >4sq"
A4413*	2 pc drainable ost pouch
A4414*	Ostomy sknbarr w flng <=4sq"
A4415*	Ostomy skn barr w flng >4sq"
A4416*	Ost pch clsd w barrier/filtr
A4417*	Ost pch w bar/bltinconv/fltr
A4418*	Ost pch clsd w/o bar w filtr
A4419*	Ost pch for bar w flange/flt
A4420*	Ost pch clsd for bar w lk fl
A4421*	Ostomy supply misc
A4422*	Ost pouch absorbent material
A4423*	Ost pch for bar w lk fl/fltr
A4424*	Ost pch drain w bar & filter
A4425*	Ost pch drain for barrier fl
A4426*	Ost pch drain 2 piece system
A4427*	Ost pch drain/barr lk flng/f
A4428*	Urine ost pouch w faucet/tap
A4429*	Urine ost pouch w bltinconv

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A4430*	Ost urine pch w b/bltin conv
A4431*	Ost pch urine w barrier/tapv
A4432*	Os pch urine w bar/fange/tap
A4433*	Urine ost pch bar w lock fln
A4434*	Ost pch urine w lock flng/ft
A4450	Non-waterproof tape
A4452	Waterproof tape
A4455	Adhesive remover per ounce
A4458	Reusable enema bag
A4461	Surgicl dress hold non-reuse
A4463	Surgical dress holder reuse
A4465	Non-elastic extremity binder
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4520	Incontinence garment anytype
A4550	Surgical trays
A4556	Electrodes, pair
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4559	Coupling gel or paste
A4649	Surgical supplies
A4670	Auto blood pressure monitor
A4930	Sterile, gloves per pair
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5071*	Urinary pouch w/barrier
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5083*	Stoma absorptive cover
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6011	Collagen gel/paste wound fil
A6010	Collagen based wound filler
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6200	Compos drsg <=16 no border
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no border
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6216	Non-sterile gauze<=16 sq in
A6217	Non-sterile gauze>16<=48 sq
A6218	Non-sterile gauze > 48 sq in
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A6230	Gauze > 48 sq in water/salne
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6250	Skin seal protect moisturizr
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b
A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6260	Wound cleanser any type/size
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6407	Packing strips, non-impreg
A6410	Sterile eye pad
A6411	Non-sterile eye pad
A6412	Occlusive eye patch

Bundled HCPCS Codes	
Code	**Abbreviated Description**
A6413	Adhesive bandage, first-aid
A6441	Pad band w>=3” <5”/yd
A6442	Conform band n/s w<3”/yd
A6443	Conform band n/s w>=3”<5”/yd
A6444	Conform band n/s w>=5”/yd
A6445	Conform band s w <3”/yd
A6446	Conform band s w>=3” <5”/yd
A6447	Conform band s w >=5”/yd
A6448	Lt compres band <3”/yd
A6449	Lt compres band >=3” <5”/yd
A6450	Lt compres band >=5”/yd
A6451	Mod compr band w>=3”<5”/yd
A6452	High compr band w>=3”<5”yd
A6453	Self-adher band w <3”/yd
A6454	Self-adher band w>=3” <5”/yd
A6455	Self-adher band >=5”/yd
A6456	Zinc paste band w >=3”<5”/yd
A9900	Supply/accessory/service
E0230	Ice cap or collar
G0117	Glaucoma scrn hgh risk direc
G0118	Glaucoma scrn hgh risk direc
T4521	Adult size brief/diaper sm
T4522	Adult size brief/diaper med
T4523	Adult size brief/diaper lg
T4524	Adult size brief/diaper xl
T4525	Adult size pull-on sm
T4526	Adult size pull-on med
T4527	Adult size pull-on lg
T4528	Adult size pull-on xl
T4533	Youth size brief/diaper
T4534	Youth size pull-on
T4535	Disposable liner/shield/pad
T4536	Reusable pull-on any size
T4537	Reusable underpad bed size
T4539	Reuse diaper/brief any size
T4540	Reusable underpad chair size
T4541	Large disposable underpad
T4542	Small disposable underpad

APPENDIX D
NON-COVERED CODES

The descriptions and complete coding information may be found in the current CPT® or HCPCS Manuals.

Non-Covered CPT® Code
0017T
0019T
0026T
0028T
0030T
0031T
00326
0032T
0046T
0047T
00529
00561
0058T
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Non-Covered CPT® Code
0096T
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0100T
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0102T
0103T
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0105T
0111T
0123T
0126T
0130T
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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20982
21685
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22525
22526
22527
22857
22862
22865
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31520
31601
32503
32504
33140
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35510
35512
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Non-Covered CPT® Code
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36400
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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83009
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84591
84830
85055
86146
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered CPT® Code
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Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
A0432	PI volunteer ambulance co
A0888	Noncovered ambulance mileage
A0998	Ambulance resp/treatment
A4261	Cervical cap contraceptive
A4266	Diaphragm
A4267	Male condom
A4268	Female condom
A4269	Spermicide
A4281	Replacement breastpump tube
A4282	Replacement breastpump adpt
A4283	Replacement breastpump cap
A4284	Replcmnt breast pump shield
A4285	Replcmnt breast pump bottle
A4286	Replcmnt breastpump lok ring
A4561	Pessary rubber, any type
A4562	Pessary, non rubber,any type
A4570	Splint
A4580	Cast supplies (plaster)
A4590	Special casting material
A4633	Uvl replacement bulb
A4634	Replacement bulb th lightbox
A4638	Repl batt pulse gen sys
A4639	Infrared ht sys replcmnt pad
A4931	Reusable oral thermometer
A4932	Reusable rectal thermometer
A7025	Replace chest compress vest
A7026	Replace chst cmprss sys hose
A7044	PAP oral interface
A9152	Single vitamin nos
A9153	Multi-vitamin nos
A9180	Lice treatment, topical
A9270	Non-covered item or service
A9282	Wig any type
A9300	Exercise equipment
B4103	EF ped fluid and electrolyte
B4158	EF ped complete intact nut
B4159	EF ped complete soy based
B4160	EF ped caloric dense>/=0.7kc
B4161	EF ped hydrolyzed/amino acid
B4162	EF ped specmetabolic inherit
C1821	Interspinous implant
C2614	Probe, perc lumb disc
C2634	Brachytx source, HA, I-125

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
C2635	Brachytx source, HA, P-103
C2636	Brachytx linear source, P-103
C2637	Brachytx, Ytterbium-169
C8921	Comp transtho echo w/contr
C8922	Limit transtho echo w/contr
C8926	Cong TEE w/contr, int/rept
C9238	Inj, levetiracetam
C9725	Place endorectal app
C9726	Rxt breast appl place/remov
D0145	Oral evaluation, pt < 3yrs
D0180	Comp periodontal evaluation
D0421	Gen tst suscept oral disease
D0431	Diag tst detect mucos abnorm
D1206	Topical fluoride varnish
D1320	Tobacco counseling
D4241	Gngvl flap w rootplan 1-3 th
D4261	Osseous surgl-3teethperquad
D4342	Periodontal scaling 1-3teeth
D6985	Pediatric partial denture fx
D7283	Place device impacted tooth
D7411	Excision benign lesion>1.25c
D7412	Excision benign lesion compl
D7413	Excision malig lesion<=1.25c
D7414	Excision malig lesion>1.25cm
D7415	Excision malig les complicat
D7472	Removal of torus palatinus
D7473	Remove torus mandibularis
D7485	Surg reduct osseoustuberosit
D7963	Frenuloplasty
D7972	Surg redct fibrous tuberosit
D9999	Adjunctive procedure
E0190	Positioning cushion
E0200	Heat lamp without stand
E0202	Phototherapy light w/ photom
E0203	Therapeutic lightbox tabletp
E0205	Heat lamp with stand
E0210	Electric heat pad standard
E0215	Electric heat pad moist
E0217	Water circ heat pad w pump
E0218	Water circ cold pad w pump
E0220	Hot water bottle
E0221	Infrared heating pad system
E0225	Hydrocollator unit

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
E0235	Paraffin bath unit, portable
E0236	Pump for water circulating p
E0238	Heat pad non-electric moist
E0239	Hydrocollator unit portable
E0249	Pad water circulating heat u
E0300	Enclosed ped crib hosp grade
E0328	Ped hospital bed, manual
E0329	Ped hospital bed semi/elect
E0425	Gas system stationary compre
E0430	Oxygen system gas portable
E0435	Oxygen system liquid portabl
E0440	Oxygen system liquid station
E0500	Ippb all types
E0602	Breast pump
E0603	Electric breast pump
E0604	Hosp grade elec breast pump
E0618	Apnea monitor
E0619	Apnea monitor w recorder
E0691	Uvl pnl 2 sq ft or less
E0692	Uvl sys panel 4 ft
E0693	Uvl sys panel 6 ft
E0694	Uvl md cabinet sys 6 ft
E0720	TENS two lead
E0731	Conductive garment for tens
E0740	Incontinence treatment systm
E0744	Neuromuscular stim for scoli
E0755	Electronic salivary reflex s
E0762	Trans elec jt stim dev sys
E0765	Nerve stimulator for tx n&v
E0769	Electric wound treatment dev
E0941	Gravity assisted traction de
E1011	Ped wc modify width adjustm
E1014	Reclining back add ped w/c
E1037	Transport chair, ped size
E1229	Pediatric wheelchair NOS
E1231	Rigid ped w/c tilt-in-space
E1232	Folding ped wc tilt-in-space
E1233	Rig ped wc tltnspc w/o seat
E1234	Fld ped wc tltnspc w/o seat
E1235	Rigid ped wc adjustable
E1236	Folding ped wc adjustable
E1237	Rgd ped wc adjstabl w/o seat
E1238	Fld ped wc adjstabl w/o seat

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
E1239	Ped power wheelchair NOS
E1300	Whirlpool, protable
E1310	Whirlpool, non-portable
E2120	Pulse gen sys tx endolymp fl
E2291	Planar back for ped size wc
E2292	Planar seat for ped size wc
E2293	Contour back for ped size wc
E2294	Contour seat for ped size wc
E8000	Posterior gait trainer
E8001	Upright gait trainer
E8002	Anterior gait trainer
G0128	CORF skilled nursing service
G0129	Occ therapy, partial hosp
G0155	Svcs of clin soc wkr under hm hlth, ea 15 min
G0176	OPPS/PHP;activity therapy
G0179	MD recert HHA patient
G0180	MD certification HHA patient
G0181	Home health care supervision
G0182	Hospice care supervision
G0219	PET img wholbod melano non-co
G0235	PET not otherwise specified
G0246	Followup eval of foot pt lop
G0247	Routine footcare pt w lops
G0251	Stereotactic radiosurgery
G0252	PET imaging
G0255	Current percep threshold tst
G0268	Removal of impacted wax md
G0270	MNT subs tx for change dx
G0271	Group MNT 2 or more 30 mins
G0290	Drug-eluting stents, single
G0291	Drug-eluting stents,each add
G0293	Non-cov surg proc,clin trial
G0294	Non-cov proc, clinical trial
G0295	Electromagnetic therapy onc
G0308	ESRD related svc 4+mo<2yrs
G0309	ESRD related svc 2-3mo<2yrs
G0310	ESRD related svc 1 visit<2yr
G0311	ESRD related svs 4+mo 2-11yr
G0312	ESRD relate svs 2-3 mo 2-11y
G0313	ESRD related svs 1 mon 2-11y
G0314	ESRD related svs 4+ mo 12-19
G0320	ESRD related svs home under2

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G0321	ESRD related svs home mo<2ys
G0322	ESRD relate svs home mo12-19
G0324	ESRD related svs home/dy<2y
G0325	ESRD relate home/dy 2-11 yr
G0326	ESRD relate home/dy 12-19y
G0328	Fecal blood screening immunoassay.
G0329	Electromagnetic tx for ulcers
G0333	Dispense fee initial 30 day
G0341	Percutaneous Islet cell trans
G0342	Laparoscopy Islet cell trans
G0343	Laparotomy Islet cell trans
G0344	Initial preventive exam
G0366	EKG for initial prevent exam
G0367	EKG tracing for initial prev
G0368	EKG interpret & report preve
G0377	Administra Part D vaccine
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G3001	Admin + supply, tositumomab
G8006	AMI pt recd aspirin at arriv
G8007	AMI pt did not receiv aspiri
G8008	AMI pt ineligible for aspiri
G8009	AMI pt recd Bblock at arr
G8010	AMI pt did not rec bblock
G8011	AMI pt inelig Bbloc at arriv
G8012	Pneum pt recv antibiotic 4 h
G8013	Pneum pt w/o antibiotic 4 hr
G8014	Pneum pt not elig antibiotic
G8015	Diabetic pt w/ HBA1c>9%
G8016	Diabetic pt w/ HBA1c<or=9%
G8017	DM pt inelig for HBA1c measu
G8018	Care not provided for HbA1c
G8019	Diabetic pt w/LDL>= 100mg/dl
G8020	Diab pt w/LDL< 100mg/dl
G8021	Diab pt inelig for LDL meas
G8022	Care not provided for LDL
G8023	DM pt w BP>=140/80
G8024	Diabetic pt wBP<140/80
G8025	Diabetic pt inelig for BP me
G8026	Diabet pt w no care re BP me
G8027	HF p w/LVSD on ACE-I/ARB
G8028	HF pt w/LVSD not on ACE-I/AR
G8029	HF pt not elig for ACE-I/ARB

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8030	HF pt w/LVSD on Bblocker
G8031	HF pt w/LVSD not on Bblocker
G8032	HF pt not elig for Bblocker
G8033	PMI-CAD pt on Bblocker
G8034	PMI-CAD pt not on Bblocker
G8035	PMI-CAD pt inelig Bblocker
G8036	AMI-CAD pt doc on antiplatel
G8037	AMI-CAD pt not docu on antip
G8038	AMI-CAD inelig antiplate mea
G8039	CAD pt w/LDL>100mg/dl
G8040	CAD pt w/LDL<or=100mg/dl
G8041	CAD pt not eligible for LDL
G8051	Osteoporosis assess
G8052	Osteopor pt not assess
G8053	Pt inelig for osteopor meas
G8054	Falls assess not docum 12 mo
G8055	Falls assess w/ 12 mon
G8056	Not elig for falls assessmen
G8057	Hearing assess receive
G8058	Pt w/o hearing assess
G8059	Pt inelig for hearing assess
G8060	Urinary incont pt assess
G8061	Pt not assess for urinary in
G8062	Pt not elig for urinary inco
G8075	ESRD pt w/ dialy of URR>=65%
G8076	ESRD pt w/ dialy of URR<65%
G8077	ESRD pt not elig for URR/KtV
G8078	ESRD pt w/Hct>or=33
G8079	ESRD pt w/Hct<33
G8080	ESRD pt inelig for HCT/Hgb
G8081	ESRD pt w/ auto AV fistula
G8082	ESRD pt w other fistula
G8093	COPD pt rec smoking cessat
G8094	COPD pt w/o smoke cessat int
G8099	Osteopo pt given Ca+VitD sup
G8100	Osteop pt inelig for Ca+VitD
G8103	New dx osteo pt w/antiresorp
G8104	Osteo pt inelig for antireso
G8106	Bone dens meas test perf
G8107	Bone dens meas test inelig
G8108	Pt receiv influenza vacc
G8109	Pt w/o influenza vacc
G8110	Pt inelig for influenza vacc

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8111	Pt receiv mammogram
G8112	Pt not doc mammogram
G8113	Pt ineligible mammography
G8114	Care not provided for mamogr
G8115	Pt receiv pneumo vacc
G8116	Pt did not rec pneumo vacc
G8117	Pt was inelig for pneumo vac
G8126	Pt treat w/antidepress12wks
G8127	Pt not treat w/antidepres12w
G8128	Pt inelig for antidepres med
G8129	Pt treat w/antidepres for 6m
G8130	Pt not treat w/antidepres 6m
G8131	Pt inelig for antidepres med
G8152	Pt w/AB 1 hr prior to incisi
G8153	Pt not doc for AB 1 hr prior
G8154	Pt ineligi for AB therapy
G8155	Pt recd thromboemb prophylax
G8156	Pt did not rec thromboembo
G8157	Pt ineligi for thrombolism
G8159	Pt w/CABG w/o IMA
G8162	Iso CABG pt w/o preop Bblock
G8164	Iso CABG pt w/prolng intub
G8165	Iso CABG pt w/o prolng intub
G8166	Iso CABG req surg rexpo
G8167	Iso CABG w/o surg explo
G8170	CEA/ext bypass pt on aspirin
G8171	Pt w/carot endarct/ext bypas
G8172	CEA/ext bypass pt not on asp
G8182	CAD pt care not prov LDL
G8183	HF/atrial fib pt on warfarin
G8184	HF/atrial fib pt inelig warf
G8185	Osteoarth pt w/ assess pain
G8186	Osteoarth pt inelig assess
G8193	Antibio not doc prior surg
G8196	Antibio not docum prior surg
G8200	Cefazolin not docum prophy
G8204	MD not doc order to d/c anti
G8209	Clinician did not doc
G8214	Clini not doc order VTE
G8217	Pt not received DVT proph
G8219	Received DVT proph day 2
G8220	Pt not rec DVT proph day 2
G8221	Pt inelig for DVT proph

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8223	Pt not doc for presc antipla
G8226	Pt no prescr anticoa at D/C
G8231	Pt not doc for admin t-PA
G8234	Pt not doc dysphagia screen
G8238	Pt not doc to rec rehab serv
G8240	Inter carotid stenosis30-99%
G8243	Pt not doc MRI/CT w/o lesion
G8246	Pt inelig hx w new/chg mole
G8248	Pt w/one alarm symp not doc
G8251	Pt not doc w/Barretts, endo
G8254	Pt w/no doc order for barium
G8257	Pt not doc rev meds D/C
G8260	Pt not doc to have dec maker
G8263	Pt not doc assess urinary in
G8266	Pt not doc charc urin incon
G8268	Pt not doc rec care urin inc
G8271	Pt no doc screen fall
G8274	Clini not doc pres/abs alarm
G8276	Pt not doc mole change
G8279	Pt not doc rec PE
G8282	Pt not doc to rec couns
G8285	Pt did not rec pres osteo
G8289	Pt not doc rec Ca/Vit D
G8293	COPD pt w/o spir results
G8296	COPD pt not doc bronch ther
G8298	Pt doc optic nerve eval
G8299	Pt not doc optic nerv eval
G8302	Pt doc w/ target IOP
G8303	Pt not doc w/ IOP
G8304	Clin doc pt inelig IOP
G8305	Clin not prov care POAG
G8306	POAG w/ IOP rec care plan
G8307	POAG w/ IOP no care plan
G8308	POAG w/ IOP not doc plan
G8310	Pt not doc rec antiox
G8314	Pt not doc to rec mac exam
G8318	Pt doc not have visual func
G8322	Pt not doc pre axial leng
G8326	Pt not doc rec fundus exam
G8330	Pt not doc rec dilated mac
G8334	Doc of macular not giv MD
G8338	Clin not doc pt test osteo
G8341	Pt not doc for DEXA

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8345	Pt not doc have DEXA
G8351	Pt not doc ECG
G8354	Pt not rec aspirin prior ER
G8357	Pt not doc to have ECG
G8360	Pt not doc vital signs recor
G8362	Pt not doc 02 SAT assess
G8365	Pt not doc mental status
G8367	Pt not doc have empiric AB
G8370	Asthma pt w survey not docum
G8371	Chemother not rec stg3 colon
G8372	Chemother rec stg 3 colon ca
G8373	Chemo plan docum prior chemo
G8374	Chemo plan not doc prior che
G8375	CLL pt w/o doc flow cytometr
G8376	Brst ca pt inelig tamoxifen
G8377	MD doc colon ca pt inelig ch
G8378	MD doc pt inelig rad therapy
G8379	Radiat tx recom doc12mo ov
G8380	Pt w stgIC-3Brst ca w/o tam
G8381	Pt w stgIC-3Brst ca rec tam
G8382	MM pt w/o doc IV bisphophon
G8383	Radiation rec not doc 12mo o
G8384	MDS pt w/o base cytogen test
G8385	Diab pt w nodoc Hgb A1c 12m
G8386	Diab pt w nodoc LDL 12m
G8387	ESRD pt w Hct/Hgb not docume
G8388	ESRD pt w URR/Ktv not doc el
G8389	MDS pt no doc Fe prior EPO
G8390	Diabetic w/o document BP 12m
G8391	Pt w asthma no doc med or tx
G8395	LVEF>=40% doc normal or mild
G8396	LVEF not performed
G8397	Dil macula/fundus exam/w doc
G8398	Dil macular/fundus not perfo
G8399	Pt w/DXA document or order
G8400	Pt w/DXA no document or orde
G8401	Pt inelig osteo screen measu
G8402	Smoke preven interven counse
G8403	Smoke preven nocounsel
G8404	Low extemity neur exam docum
G8405	Low extemity neur not perfor
G8406	Pt inelig lower extrem neuro
G8407	ABI documented

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8408	ABI not documented
G8409	Pt inelig for ABI measure
G8410	Eval on foot documented
G8415	Eval on foot not performed
G8416	Pt inelig footwear evaluatio
G8417	BMI >=30 calcuate w/followup
G8418	BMI < 22 calcuate w/followup
G8419	BMI>=30or<22 cal no followup
G8420	BMI<30 and >=22 calc & docu
G8421	BMI not calculated
G8422	Pt inelig BMI calculation
G8423	Pt screen flu vac & counsel
G8424	Flu vaccine not screen
G8425	Flu vaccine screen not curre
G8426	Pt not approp screen & counc
G8427	Doc meds verified w/pt or re
G8428	Meds document w/o verifica
G8429	Incomplete doc pt on meds
G8430	Pt inelig med check
G8431	Clin depression screen doc
G8432	Clin depression screen not d
G8433	Pt inelig for depression scr
G8434	Cognitive impairment screen
G8435	Cognitive screen not documen
G8436	Pt inelig for cognitive impa
G8437	Tx plan develop & document
G8438	Tx plan develop & not docum
G8439	Pt inelig for co-develp tx p
G8440	Pain assessment document
G8441	No document of pain assess
G8442	Pt inelig pain assessment
G8443	Prescription by E-Prescrib s
G8445	Prescrip not gen at encounte
G8446	Some prescrib handwritten or
G8447	Pt visit doc using CCHIT cer
G8448	Pt visit docum w/non-CCHIT c
G8449	Pt not doc w/EMR due to syst
G8450	Beta-bloc rx pt w/abn lvef
G8451	Pt w/abn lvef inelig b-bloc
G8452	Pt w/abn lvef b-bloc no rx
G8453	Tob use cess int counsel
G8454	Tob use cess int no counsel
G8455	Current tobacco smoker

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G8456	Smokeless tobacco user
G8457	Tobacco non-user
G8458	Pt inelig geno no antvir tx
G8459	Doc pt rec antivir treat
G8460	Pt inelig RNA no antvir tx
G8461	Pt rec antivir treat hep c
G8462	Pt inelig couns no antvir tx
G8463	Pt rec antiviral treat doc
G8464	Pt inelig; lo to no dter rsk
G8465	High risk recurrence pro ca
G8466	Pt inelig suic; MDD remis
G8467	New dx init/rec episode MDD
G8468	ACE/ARB rx pt w/abn lvef
G8469	Pt w/abn lvef inelig ACE/ARB
G8470	Pt w/ normal lvef
G8471	LVEF not performed/doc
G8472	ACE/ARB no rx pt w/abn lvef
G8473	ACE/ARB thxpy rx'd
G8474	ACE/ARB not rx'd; doc reas
G8475	ACE/ARB thxpy not rx'd
G8476	BP sys <130 and dias <80
G8477	BP sys>=130 and/or dias >=80
G8478	BP not performed/doc
G8479	MD rx'd ACE/ARB thxpy
G8480	Pt inelig ACE/ARB thxpy
G8481	MD not rx'd ACE/ARB thxpy
G8482	Flu immunize order/admin
G8483	Flu imm no ord/admin doc rea
G8484	Flu immunize no order/admin
G9002	MCCD,maintenance rate
G9003	MCCD, risk adj hi, initial
G9004	MCCD, risk adj lo, initial
G9013	ESRD demo bundle level I
G9014	ESRD demo bundle-level II
G9016	Demo-smoking cessation coun
G9017	Amantadine HCL, oral
G9018	Zanamivir, inh pwdr
G9019	Oseltamivir phosp
G9020	Rimantadine HCL
G9035	Oseltamivir phosp, brand
G9036	Rimantadine HCL, brand
G9041	Low vision serv occupational
G9042	Low vision orient/mobility

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G9043	Low vision rehab therapist
G9044	Low vision rehab teacher
G9050	Oncology work-up evaluation
G9051	Oncology treatment decision
G9052	Onc surveillance for disease
G9053	Onc expectant management pt
G9054	Onc supervision palliative
G9055	Onc visit unspecified NOS
G9056	Onc prac mgmt adheres guide
G9057	Onc pract mgmt differs guide
G9058	Onc prac mgmt disagree w/gui
G9059	Onc prac mgmt pt opt alterna
G9060	Onc prac mgmt dif pt comorb
G9061	Onc prac cond noadd by guide
G9062	Onc prac guide differs nos
G9063	Onc dx nsclc stgI no dx prog
G9064	Onc dx nsclc stg2 no dx prog
G9065	Onc dx nsclc stg3A nodx prog
G9066	Onc dx nsclc stg3B-4 metasta
G9067	Onc dx nsclc dx unknown nos
G9068	Onc dx nsclc/sclc limited
G9069	Onc dx sclc/nsclc ext at dx
G9070	Onc dx sclc/nsclc ext unknwn
G9071	Onc dx brst stg1 2B no dx pr
G9072	Onc dx brst stg1-2 noprogres
G9073	Onc dx brst stg3-w/progres
G9074	Onc dx brst stg3-noprogress
G9075	Onc dx brst metastic/ recur
G9077	Onc dx prostate T1no progres
G9078	Onc dx prostate T2no progres
G9079	Onc dx prostate T3b-T4noprog
G9080	Onc dx prostate w/rise PSA
G9083	Onc dx prostate unknown NOS
G9084	Onc dx colon t1-3,n1-2,no pr
G9085	Onc dx colon T4, N0 w/o prog
G9086	Onc dx colon T1-4 no dx prog
G9087	Onc dx colon radiolg evid dx
G9088	Onc dx colon m1/mets w/o rad
G9089	Onc dx colon extent unknown
G9090	Onc dx rectal T1-2 no progr
G9091	Onc dx rectal T3 N0 no prog
G9092	Onc dx rectal T1-3,N1-2noprg
G9093	Onc dx rectal T4,N,M0 no prg

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
G9094	Onc dx rectal M1 w/mets prog
G9095	Onc dx rectal extent unknwn
G9096	Onc dx esophag T1-T3 noprog
G9097	Onc dx esophageal T4 no prog
G9098	Onc dx esophageal mets recur
G9099	Onc dx esophageal unknown
G9100	Onc dx gastric no recurrence
G9101	Onc dx gastric p R1-R2noprog
G9102	Onc dx gastric unresectable
G9103	Onc dx gastric recurrent
G9104	Onc dx gastric unknown NOS
G9105	Onc dx pancreatc p R0 res no
G9106	Onc dx pancreatc p R1/R2 no
G9107	Onc dx pancreatic unresectab
G9108	Onc dx pancreatic unknwn NOS
G9109	Onc dx head/neck T1-T2no prg
G9110	Onc dx head/neck T3-4 noprog
G9111	Onc dx head/neck M1 mets rec
G9112	Onc dx head/neck ext unknown
G9113	Onc dx ovarian stg1A-B no pr
G9114	Onc dx ovarian stg1A-B or 2
G9115	Onc dx ovarian stg3/4 noprog
G9116	Onc dx ovarian recurrence
G9117	Onc dx ovarian unknown NOS
G9123	Onc dx NHL lge Bcell relap
G9124	Onc dx NHL relapse/refractor
G9125	Onc dx NHL stg unknown
G9126	Onc dx ovarian stg IA/B
G9128	Onc dx mult myeloma stg2 hig
G9129	Onc dx mult myeloma unkwn op
G9130	Onc dx multi myeloma unknown
G9131	Onc dx brst unknown NOS
G9132	Onc dx prostate mets no cast
G9133	Onc dx prostate clinical met
G9134	Onc NHLstg 1-2 no relap no
G9135	Onc dx NHL stg 3-4 not relap
G9136	Onc dx NHL trans to lg Bcell
G9137	Onc dx NHL relapse/refractor
G9138	Onc dx NHL stg unknown
G9139	Onc dx CML dx status unknown
G9140	Frontier extended stay demo
H0016	Alcohol and/or drug services
H0021	Alcohol and/or drug training

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
H0022	Alcohol and/or drug interven
H0023	Alcohol and/or drug outreach
H0024	Alcohol and/or drug preventi
H0025	Alcohol and/or drug preventi
H0026	Alcohol and/or drug preventi
H0027	Alcohol and/or drug preventi
H0028	Alcohol and/or drug preventi
H0029	Alcohol and/or drug preventi
H0030	Alcohol and/or drug hotline
H0031	MH health assess by non-md
H0032	MH svc plan dev by non-md
H0033	Oral med adm direct observe
H0034	Med trng & support per 15min
H0035	MH partial hosp tx under 24h
H0036	Comm psy face-face per 15min
H0037	Comm psy sup tx pgm per diem
H0038	Self-help/peer svc per 15min
H0039	Asser com tx face-face/15min
H0040	Assert comm tx pgm per diem
H0041	Fos c chld non-ther per diem
H0042	Fos c chld non-ther per mon
H0043	Supported housing, per diem
H0044	Supported housing, per month
H0045	Respite not-in-home per diem
H0046	Mental health service, nos
H1010	Nonmed family planning ed
H1011	Family assessment
H2000	Comp multidisipln evaluation
H2001	Rehabilitation program 1/2 d
H2010	Comprehensive med svc 15 min
H2011	Crisis interven svc, 15 min
H2012	Behav Hlth Day Treat, per hr
H2013	Psych hlth fac svc, per diem
H2014	Skills Train and Dev, 15 min
H2015	Comp Comm Supp Svc, 15 min
H2016	Comp Comm Supp Svc, per diem
H2017	PsySoc Rehab Svc, per 15 min
H2018	PsySoc Rehab Svc, per diem
H2019	Ther Behav Svc, per 15 min
H2020	Ther Behav Svc, per diem
H2021	Com Wrap-Around Sv, 15 min
H2022	Com Wrap-Around Sv, per diem
H2023	Supported Employ, per 15 min

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
H2024	Supported Employ, per diem
H2025	Supp Maint Employ, 15 min
H2026	Supp Maint Employ, per diem
H2027	Psychoed Svc, per 15 min
H2028	Sex Offend Tx Svc, 15 min
H2029	Sex Offend Tx Svc, per diem
H2030	MH Clubhouse Svc, per 15
H2031	MH Clubhouse Svc, per diem
H2032	Activity Therapy, per 15 min
H2033	Multisys Ther/Juvenile 15min
H2034	A/D Halfway House, per diem
H2035	A/D Tx Program, per hour
H2036	A/D Tx Program, per diem
H2037	Dev Delay Prev Dp Ch, 15 min
J0128	Abarelix injection
J0135	Adalimumab injection
J0190	Injection, biperiden, 2 mg
J0215	Alefacept
J0220	Aglucosidase alfa injection
J0278	Amikacin sulfate injection
J0390	Chloroquine injection
J0395	Arbutamine HCl injection
J0520	Bethanechol chloride inject
J0583	Bivalirudin
J0636	Inj calcitriol per 0.1 mcg
J0706	Caffeine citrate injection
J0710	Cephapirin sodium injection
J0760	Colchicine injection
J0795	Corticorelin ovine triflutal
J0970	Estradiol valerate injection
J1000	Depo-estradiol cypionate inj
J1051	Medroxyprogesterone inj
J1055	Medrxyprogester acetate inj
J1056	MA/EC contraceptiveinjection
J1270	Injection, doxercalciferol
J1300	Eculizumab injection
J1330	Ergonovine maleate injection
J1380	Estradiol valerate 10 MG inj
J1390	Estradiol valerate 20 MG inj
J1410	Inj estrogen conjugate 25 MG
J1430	Ethanolamine oleate 100 mg
J1435	Injection estrone per 1 MG
J1457	Gallium nitrate injection

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
J1458	Galsulfase injection
J1565	RSV-ivig
J1595	Injection glatiramer acetate
J1700	Hydrocortisone acetate inj
J1710	Hydrocortisone sodium ph inj
J1743	Idursulfase injection
J1810	Droperidol/fentanyl inj
J1890	Cephalothin sodium injection
J2170	Mecasermin injection
J2180	Meperidine/promethazine inj
J2210	Methylergonovin maleate inj
J2271	Morphine so4 injection 100mg
J2278	Ziconotide injection
J2323	Natalizumab injection
J2425	Palifermin injection
J2501	Paricalcitol
J2503	Pegaptanib sodium injection
J2504	Pegademase bovine, 25 iu
J2505	Injection, pegfilgrastim 6mg
J2590	Oxytocin injection
J2670	Totazoline hcl injection
J2675	Progesterone Injection
J2765	Injection, metoclopramide hcl
J2778	Ranibizumab injection
J2783	Rasburicase
J2805	Sincalide injection
J2850	Inj secretin synthetic human
J2940	Somatrem injection
J2941	Somatropin injection
J2950	Promazine hcl injection
J3110	Teriparatide injection
J3140	Testosterone suspension inj
J3150	Testosteron propionate inj
J3285	Treprostinil injection
J3310	Perphenazine injeciton
J3315	Triptorelin pamoate
J3350	Urea injection
J3355	Urofollitropin, 75 iu
J3364	Urokinase 5000 IU injection
J3396	Verteporfin injection
J3400	Triflupromazine hcl inj
J3530	Nasal vaccine inhalation
J3570	Laetrile amygdalin vit B17

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
J7300	Intraut copper contraceptive
J7302	Levonorgestrel iu contracept
J7303	Contraceptive vaginal ring
J7304	Contraceptive hormone patch
J7306	Levonorgestrel implant sys
J7307	Etonogestrel implant system
J7308	Aminolevulinic acid hcl top
J7518	Mycophenolic acid
J7628	Bitolterol mes inhal sol con
J7629	Bitolterol mes inh sol u d
J7635	Atropine inhal sol con
J7636	Atropine inhal sol unit dose
J7637	Dexamethasone inhal sol con
J7638	Dexamethasone inhal sol u d
J7642	Glycopyrrolate inhal sol con
J7643	Glycopyrrolate inhal sol u d
J7647	Isoetharine comp con
J7648	Isoetharine hcl inh sol con
J7649	Isoetharine hcl inh sol u d
J7650	Isoetharine comp unit
J7658	Isoproterenolhcl inh sol con
J7659	Isoproterenol hcl inh sol ud
J7680	Terbutaline so4 inh sol con
J7681	Terbutaline so4 inh sol u d
J8501	Oral aprepitant
J8515	Cabergoline, oral 0.25mg
J8565	Gefitinib oral
J9010	Alemtuzumab injection
J9025	Azacitidine injection
J9027	Clofarabine injection
J9035	Bevacizumab injection
J9055	Cetuximab injection
J9070	Cyclophosphamide 100 MG inj
J9080	Cyclophosphamide 200 MG inj
J9093	Cyclophosphamide lyophilized
J9094	Cyclophosphamide lyophilized
J9165	Diethylstilbestrol injection
J9175	Elliotts b solution per ml
J9219	Leuprolide acetate implant
J9225	Histrelin implant
J9226	Supprelin LA implant
J9303	Panitumumab injection
J9357	Valrubicin, 200 mg

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
J9395	Injection, Fulvestrant
K0606	AED garment w elec analysis
K0607	Repl batt for AED
K0608	Repl garment for AED
K0609	Repl electrode for AED
K0730	Ctrl dose inh drug deliv sys
L1001	CTLSO infant immobilizer
L5856	Elec knee-shin swing/stance
L5857	Elec knee-shin swing only
L5858	Stance phase only
L7008	Pediatric electric hand
L7611	Ped term dev, hook, vol open
L7612	Ped term dev, hook, vol clos
L7613	Ped term dev, hand, vol open
L7614	Ped term dev, hand, vol clos
L8609	Artificial cornea
L8680	Implt neurostim elctr each
L8681	Pt prgrm for implt neurostim
L8682	Implt neurostim radiofq rec
L8683	Radiofq trsmtr for implt neu
L8684	Radiof trsmtr implt scrl neu
L8685	Implt nrostm pls gen sng rec
L8686	Implt nrostm pls gen sng non
L8687	Implt nrostm pls gen dua rec
L8688	Implt nrostm pls gen dua non
L8689	External recharging system
M0075	Cellular therapy
M0076	Prolotherapy
M0100	Intragastric hypothermia
M0300	IV chelationtherapy
M0301	Fabric wrapping of aneurysm
P2031	Hair analysis
P7001	Culture bacterial urine
P9604	One-way allow prorated trip
Q0035	Cardiokymography
Q0144	Azithromycin dihydrate, oral
Q0482	microprcsr cu combo vad, rep
Q0483	monitor elec vad, rep
Q0484	monitor elec or comb vad rep
Q0485	monitor cable elec vad, rep
Q0486	mon cable elec/pneum vad rep
Q0487	leads any type vad, rep only
Q0488	pwr pack base elec vad, rep

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
Q0489	pwr pck base combo vad, rep
Q0490	emr pwr source elec vad, rep
Q0491	emr pwr source combo vad rep
Q0492	emr pwr cbl elec vad, rep
Q0493	emr pwr cbl combo vad, rep
Q0494	emr hd pmp elec/combo, rep
Q0495	charger elec/combo vad, rep
Q0496	battery elec/combo vad, rep
Q0497	bat clps elec/comb vad, rep
Q0498	holster elec/combo vad, rep
Q0499	belt/vest elec/combo vad rep
Q0500	filters elec/combo vad, rep
Q0501	shwr cov elec/combo vad, rep
Q0502	mobility cart pneum vad, rep
Q0503	battery pneum vad replacemnt
Q0504	pwr adpt pneum vad, rep veh
Q0505	miscl supply/accessory vad
Q0510	Dispens fee immunosupressive
Q0511	Sup fee antiem,antica,immuno
Q0512	Px sup fee anti-can sub pres
Q0513	Disp fee inhal drugs/30 days
Q0514	Disp fee inhal drugs/90 days
Q0515	Sermorelin acetate injection
Q3025	IM inj interferon beta 1-a
Q3026	Subc inj interferon beta-1a
Q4007	Cast sup long arm ped, pl
Q4008	Cast sup, long arm ped, fib
Q4011	Cast sup sh arm ped, pl
Q4012	Cast sup sh arm ped, fib
Q4015	Cast sup gauntlet ped,
Q4016	Cast sup gauntlet ped, fib
Q4019	Cast sup l arm splint ped, pl
Q4020	Cast sup l arm splint ped, fib
Q4023	Cast sup sh arm splint ped, pl
Q4024	Cast sup sh arm splint ped, fib
Q4027	Cast sup hip spica, pl
Q4028	Cast sup, hip spica, fib
Q4031	Cast sup, long leg ped, pl
Q4032	Cast sup, long leg ped, fib
Q4035	Cast sup, leg cylinder ped, pl
Q4036	Cast sup, leg cylinder ped, fib
Q4039	Cast sup, sh leg ped, pl
Q4040	Cast sup, sh leg ped, fib

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
Q4043	Cast sup, l leg splintped, pl
Q4044	Cast sup, l leg splint ped, fib
Q4047	Cast sup, sh leg splint ped, pl
Q4048	Cast sup, sh leg splint ped, fib
Q4082	Drug/bio NOC part B drug CAP
Q5002	Hospice in assisted living
S0012	Butorphanol tartrate, nasal
S0014	Tacrine hydrochloride, 10 mg
S0017	Injection, aminocaproic acid
S0020	Injection, bupivicaine hydro
S0021	Injection, ceftoperazone sod
S0023	Injection, cimetidine hydroc
S0028	Injection, famotidine, 20 mg
S0030	Injection, metronidazole
S0032	Injection, nafcillin sodium
S0034	Injection, ofloxacin, 400 mg
S0039	Injection, sulfamethoxazole
S0040	Injection, ticarcillin disod
S0073	Injection, aztreonam, 500 mg
S0074	Injection, cefotetan disodiu
S0077	Injection, clindamycin phosp
S0078	Injection, fosphenytoin sodi
S0080	Injection, pentamidine iseth
S0081	Injection, piperacillin sodi
S0090	Sildenafil citrate, 25 mg
S0104	Zidovudine, oral, 100 mg
S0106	Bupropion hcl sr 60 tablets
S0108	Mercaptopurine 50 mg
S0109	Methadone oral 5 mg
S0117	Tretinoin topical, 5g
S0122	Inj menotropins 75 iu
S0126	Inj follitropin alfa 75 iu
S0128	Inj follitropin beta 75 iu
S0132	Inj ganirelix acetat 250 mcg
S0136	Clozapine, 25 mg
S0137	Didanosine, 25 mg
S0138	Finasteride, 5 mg
S0139	Minoxidil, 10 mg
S0140	Saquinavir, 200 mg
S0141	Zalcitabine, 0.375 mg
S0156	Exemestane, 25 mg
S0157	Becaplermin gel 1%, 0.5 gm
S0160	Dextroamphetamine

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S0161	Calcitriol
S0162	Injection efalizumab
S0166	Inj olanzapine 2.5mg
S0177	Levamisole 50 mg
S0194	Vitamin suppl 100 caps
S0195	Pneumococcal conjugate vac
S0196	Poly-l-lactic acid 1ml face
S0197	Prenatal vitamins 30 day
S0201	Prt hosp svcs, less than 24 hrs, per diem
S0207	Parmedic intercept, non-hosp based
S0208	Paramed intrcept nonvol
S0209	WC van mileage per mi
S0215	Nonemerg transp mileage
S0220	Medical conference by physic
S0221	Medical conference, 60 min
S0250	Comp geriatr assmt team
S0255	Hospice refer visit nonmd
S0257	End of life counseling
S0260	H&P for surgery
S0265	Genetic counsel 15 mins
S0270	Home std case rate 30 days
S0271	Home hospice case 30 days
S0272	Home episodic case 30 days
S0273	MD home visit outside cap
S0274	Nurse practr visit outs cap
S0302	Completed EPSDT
S0310	Hospitalist visit
S0315	Disease mgmt prgrm, init
S0316	Disease mgmt prgrm, flw up
S0317	Disease mgmt per diem
S0320	Phone call by RN to dis mgmt prgrm
S0340	Lifestyle mod 1st stage
S0341	Lifestyle mod 2 or 3 stage
S0342	Lifestyle mod 4th stage
S0345	Home ECG monitrng global 24h
S0346	Home ECG monitrng tech 24h
S0347	Home ECG monitrng prof 24hr
S0390	Rout foot care per visit
S0400	Global eswl kidney
S0500	Dispos cont lens
S0504	Singl prscrp lens
S0506	Bifoc prscp lens
S0508	Trifoc prscrp lens

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S0510	Non-prscrp lens
S0512	Daily cont lens
S0514	Color cont lens
S0515	Scleral lens liquid bandage
S0516	Safety frames
S0518	Sunglass frames
S0580	Polycarb lens
S0581	Nonstnd lens
S0590	Misc integral lens serv
S0592	Comp cont lens eval
S0595	New lenses in pts old frame
S0601	Screening proctoscopy
S0605	Digital rectal examination,
S0610	Annual gynecological examina
S0612	Annual gynecological examina
S0613	Ann breast exam
S0618	Audiometry for hearing aid
S0620	Routine ophthalmological exa
S0621	Routine ophthalmological exa
S0622	Phys exam for college
S0625	Digital screening retinal
S0630	Removal of sutures
S0800	Laser in situ keratomileusis
S0810	Photorefractive keratectomy
S0812	Phototherap keratect
S1001	Deluxe item
S1002	Custom item
S1015	IV tubing extension set
S1016	Non-pvc intravenous administ
S1030	Gluc monitor purchase
S1031	Gluc monitor rental
S1040	Cranial remold orth, rigid
S2053	Transplantation of small int
S2054	Transplantation of multivisc
S2055	Harvesting of donor multivis
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung)
S2065	Simult panc kidn trans
S2068	Breast DIEP flap reconstruct
S2070	Cysto laser tx ureteral calc
S2075	Lap inc/vent hernia repair
S2076	Lap umbilical hernia repair
S2077	Lap mesh implant hern rep

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S2080	Laup
S2083	Adjustment gastric band
S2095	Transcath emboliz microspher
S2102	Islet cell tissue transplant
S2103	Adrenal tissue transplant
S2107	Adoptive immunotherapy
S2115	Periacetabular osteotomy
S2117	Arthroereisis, subtalar
S2120	Low density lipoprotein (LDL)
S2135	Neurolysis interspace foot
S2140	Cord blood harvesting
S2142	Cord blood-derived stem-cell
S2150	BMT harv/transpl 28d pkg
S2152	Solid organ transpl pkg
S2202	Echosclerotherapy
S2205	Minimally invasive direct co
S2206	Minimally invasive direct co
S2207	Minimally invasive direct co
S2208	Minimally invasive direct co
S2209	Minimally invasive direct co
S2225	Myringotomy laser-assist
S2230	Implant semi-imp hear
S2235	Implant auditory brain imp
S2260	Induced abortion 17-24 weeks
S2265	Abortion for fetal ind, 25 – 28 wks
S2266	Abortion for fetal ind, 29 – 31 wks
S2267	Abortion for fetal ind, 32 wks or grtr
S2300	Arthroscopy, shoulder, surgi
S2340	Chemodenervation of abductor
S2341	Chemodenerv adduct vocal
S2342	Nasal endoscop po debrid
S2344	Endosc balloon sinuplasty
S2348	Decompress disc RF lumbar
S2350	Diskectomy, anterior, with d
S2351	Diskectomy, anterior, with d
S2360	Vertebroplast cerv 1st
S2361	Vertebroplast cerv addl
S2400	Fetal surg congen hernia
S2401	Fetal surg urin trac obstr
S2402	Fetal surg cong cyst malf
S2403	Fetal surg pulmon sequest
S2404	Fetal surg myelomeningo
S2405	Fetal surg sacrococ teratoma

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S2409	Fetal surg noc
S2411	Fetoscop laser ther TTTS
S2900	Robotic surgical system
S3000	Bilat dil retinal exam
S3005	Eval self-assess depression
S3620	Newborn metabolic screening
S3625	Maternal triple screen test
S3626	Maternal serum quad screen
S3628	PAMG-1 rapid assay for ROM
S3630	Eosinophil blood count
S3645	HIV-1 antibody testing of or
S3650	Saliva test, hormone level;
S3652	Saliva test, hormone level;
S3655	Antisperm antibody test
S3708	Gastrointestinal fat absorpt
S3818	BRCA1 gene anal
S3819	BRCA2 gene anal
S3820	Comp BRCA1/BRCA2
S3822	Sing mutation brst/ovar
S3823	3 mutation brst/ovar
S3828	Comp MLH1 gene
S3829	Comp MSH2 gene
S3830	Gene test HNPCC comp
S3831	Gene test HNPCC single
S3833	Comp APC sequence
S3834	Sing mutation APC
S3835	Gene test cystic fibrosis
S3837	Gene test hemochromato
S3840	DNA analysis RET-oncogene
S3841	Gene test retinoblastoma
S3842	Gene test Hippel-Lindau
S3843	DNA analysis Factor V
S3844	DNA analysis deafness
S3845	Gene test alpha-thalassemia
S3846	Gene test beta-thalassemia
S3847	Gene test Tay-Sachs
S3848	Gene test Gaucher
S3849	Gene test Niemann-Pick
S3850	Gene test sickle cell
S3851	Gene test Canavan
S3852	DNA analysis APOE Alzheimer
S3853	Gene test myo musclr dyst
S3854	Gene profile panel breast

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S3855	Gene test presenilin-1 gene
S3890	Fecal DNA analysis
S3900	Surface EMG
S3902	Ballistocardiogram
S3904	Masters two step
S4005	Interim labor facility global
S4011	IVF package
S4013	Compl gift case rate
S4014	Compl zift case rate
S4015	Complete IVF case rate
S4016	Frozen IVF case rate
S4017	INV canc a stim case rate
S4018	F EMB trns canc case rate
S4020	IVF canc a aspir case rate
S4021	IVF canc p aspir case rate
S4022	Asst oocyte fert case rate
S4023	Incompl donor egg case rate
S4025	Donor serv IVF case rate
S4026	Procure donor sperm
S4027	Store prev froz embryos
S4028	Microsurg epi sperm asp
S4030	Sperm procure init visit
S4031	Sperm procure subs visit
S4035	Stimulated iui case rate
S4037	Cryo embryo transf case rate
S4040	Monit store cryo embryo 30 d
S4042	Ovulation mgmt per cycle
S4981	Insert levonorgestrel ius
S4989	Contracept IUD
S4990	Nicotine patch legend
S4991	Nicotine patch nonlegend
S4993	Contraceptive pills for bc
S4995	Smoking cessation gum
S5000	Prescription drug, generic
S5001	Prescription drug,brand name
S5010	5% dextrose and 45% saline
S5011	5% dextrose in lactated ring
S5012	5% dextrose with potassium
S5013	5% dextrose/45%saline,1000ml
S5014	5% dextrose/45%saline,1500ml
S5035	HIT routine device maint
S5036	HIT device repair
S5100	Adult daycare services 15 min

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S5101	Adult day care per half day
S5102	Adult day care per diem
S5105	Centerbased daycare perdiem
S5108	Homecare train pt 15 min
S5109	Homecare train pt session
S5110	Family homecare training 15m
S5111	Family homecare train/sessio
S5115	Nonfamily homecare train/15m
S5116	Nonfamily HC train/session
S5120	Chore services per 15 min
S5121	Chore services per diem
S5125	Attendant care service /15m
S5126	Attendant care service /diem
S5130	Homaker service nos per 15m
S5131	Homemaker service nos /diem
S5135	Adult companioncare per 15m
S5136	Adult companioncare per diem
S5140	Adult foster care per diem
S5141	Adult foster care per month
S5145	Child fostercare th per diem
S5146	Ther fostercare child /month
S5150	Unskilled respite care /15m
S5151	Unskilled respitecare /diem
S5165	Home modifications per serv
S5170	Homedelivered prepared meal
S5175	Laundry serv,ext,prof,/order
S5180	HH respiratory thrpy in eval
S5181	HH respiratory thrpy nos/day
S5185	Med reminder serv per month
S5190	Wellness assessment by nonph
S5199	Personal care item nos each
S5497	HIT cath care noc
S5498	HIT simple cath care
S5501	HIT complex cath care
S5502	HIT interim cath care
S5517	HIT declotting kit
S5518	HIT cath repair kit
S5520	HIT picc insert kit
S5521	HIT midline cath insert kit
S5522	HIT picc insert no supp
S5523	HIP midline cath insert kit
S5550	Insulin rapid 5 u
S5551	Insulin most rapid 5 u

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S5552	Insulin intermed 5 u
S5553	Insulin long acting 5 u
S5560	Insulin reuse pen 1.5 ml
S5561	Insulin reuse pen 3 ml
S5565	Insulin cartridge 150 u
S5566	Insulin cartridge 300 u
S5570	Insulin dispos pen 1.5 ml
S5571	Insulin dispos pen 3 ml
S8030	Tantalum ring application
S8035	Magnetic source imaging
S8037	mrcp
S8040	Topographic brain mapping
S8042	MRI low field
S8049	Intraoperative radiation the
S8055	Us guidance fetal reduct
S8080	Scintimammography
S8085	Fluorine-18 fluorodeoxygluco
S8092	Electron beam computed tomog
S8096	Portable peak flow meter
S8097	Asthma kit
S8100	Spacer without mask
S8101	Spacer with mask
S8110	Peak expiratory flow rate (p
S8120	O2 contents gas cubic ft
S8121	O2 contents liquid lb
S8185	Flutter device
S8186	Swivel adaptor
S8189	Trach supply noc
S8190	Electronic spirometer
S8210	Mucus trap
S8262	Mandib ortho repos device
S8265	Haberman feeder
S8270	Enuresis alarm
S8301	Infect control supplies NOS
S8415	Supplies for home delivery
S8450	Splint digit
S8451	Splint wrist or ankle
S8452	Splint elbow
S8460	Camisole post-mast
S8490	100 insulin syringes
S8940	Hippotherapy per session
S8948	Low-level laser trmt 15 min
S8950	Complex lymphedema therapy,

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S8990	PT or manip for maint
S8999	Resuscitation bag
S9001	Home uterine monitor with or
S9007	Ultrafiltration monitor
S9015	Automated EEG monitoring
S9024	Paranasal sinus ultrasound
S9025	Omnicardiogram/cardiointegra
S9034	ESWL for gallstones
S9055	Procuren or other growth fac
S9056	Coma stimulation per diem
S9061	Medical supplies and equipme
S9075	Smoking cessation treatment
S9083	Urgent care center global
S9088	Services provided in urgent
S9090	Vertebral axial decompressio
S9092	Canolith repositioning
S9097	Home visit wound care
S9098	Home phototherapy visit
S9109	CHF telemonitoring month
S9117	Back school visit
S9125	Respite care, in the home, p
S9127	Social work visit, in the ho
S9128	Speech therapy, in the home,
S9129	Occupational therapy, in the
S9131	PT in the home per diem
S9140	Diabetic Management Program,
S9141	Diabetic Management Program,
S9145	Insulin pump initiation
S9150	Evaluation by Ocularist
S9208	Home mgmt preterm labor
S9209	Home mgmt PPROM
S9211	Home mgmt gest hypertension
S9212	Hm postpar hyper per diem
S9213	Hm preeclamp per diem
S9214	Hm gest dm per diem
S9325	HIT pain mgmt per diem
S9326	HIT cont pain per diem
S9327	HIT int pain per diem
S9328	HIT pain imp pump diem
S9329	HIT chemo per diem
S9330	HIT cont chem diem
S9331	HIT intermit chemo diem
S9335	HT hemodialysis diem

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S9336	HIT cont anticoag diem
S9338	HIT immunotherapy diem
S9339	HIT periton dialysis diem
S9340	HIT enteral per diem
S9341	HIT enteral grav diem
S9342	HIT enteral pump diem
S9343	HIT enteral bolus nurs
S9345	HIT anti-hemophil diem
S9346	HIT alpha-1-proteinas diem
S9347	HIT longterm infusion diem
S9348	HIT sympathomim diem
S9349	HIT tocolysis diem
S9351	HIT cont antiemetic diem
S9353	HIT cont insulin diem
S9355	HIT chelation diem
S9357	HIT enzyme replace diem
S9359	HIT anti-tnf per diem
S9361	HIT diuretic infus diem
S9363	HIT anti-spasmotic diem
S9364	HIT tpn total diem
S9365	HIT tpn 1 liter diem
S9366	HIT tpn 2 liter diem
S9367	HIT tpn 3 liter diem
S9368	HIT tpn over 3l diem
S9370	HT inj antiemetic diem
S9372	HT inj anticoag diem
S9373	HIT hydra total diem
S9374	HIT hydra 1 liter diem
S9375	HIT hydra 2 liter diem
S9376	HIT hydra 3 liter diem
S9377	HIT hydra over 3l diem
S9379	HIT noc per diem
S9381	HIT high risk/escort
S9401	Anticoag clinic per session
S9430	Pharmacy comp/disp serv
S9434	Mod solid food suppl
S9435	Medical foods for inborn err
S9436	Lamaze class
S9437	Childbirth refresher class
S9438	Cesarean birth class
S9439	VBAC class
S9441	Asthma education
S9442	Birthing class

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S9443	Lactation class
S9444	Parenting class
S9446	PT education noc group
S9447	Infant safety class
S9449	Weight mgt class
S9451	Exercise class
S9452	Nutrition class
S9453	Smoking cessation class
S9454	Stress mgmt class
S9455	Diabetic Management Program,
S9460	Diabetic Management Program,
S9465	Diabetic Management Program,
S9470	Nutritional counseling, diet
S9472	Cardiac rehabilitation progr
S9473	Pulmonary rehabilitation pro
S9474	Enterostomal therapy by a re
S9475	Ambulatory setting substance
S9476	Vestibular rehab per diem
S9480	Intensive outpatient psychia
S9482	Family stabilization 15 min
S9484	Crisis intervention per hour
S9485	Crisis intervention mental h
S9490	HIT corticosteroid diem
S9494	HIT antibiotic total diem
S9497	HIT antibiotic q3h diem
S9500	HIT antibiotic q24h diem
S9501	HIT antibiotic q12h diem
S9502	HIT antibiotic q8h diem
S9503	HIT antibiotic q6h diem
S9504	HIT antibiotic q4h diem
S9529	Venipuncture home/snf
S9537	HT hem horm inj diem
S9538	HIT blood products diem
S9542	HT inj noc per diem
S9558	HT inj growth horm diem
S9559	HIT inj interferon diem
S9560	HT inj hormone diem
S9562	Palivizumab home inj perdiem
S9590	In home irrigation therapy
S9810	HT pharm per hour
S9900	Christian sci pract visit
S9970	Health club membership yr
S9975	Transplant related per diem

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
S9976	Lodging per diem
S9977	Meals per diem
S9981	Med record copy admin
S9986	Not medically necessary svc
S9988	Serv part of phase I trial
S9989	Services outside US
S9990	Services provided as part of
S9991	Services provided as part of
S9992	Transportation costs to and
S9994	Lodging costs (e.g. hotel ch
S9996	Meals for clinical trial par
S9999	Sales tax
T1000	Priv duty/inde nurse, to 15 mi
T1001	Nursing assessement/eval
T1002	RN services, up to 15 min
T1003	LPN/LVN serv, up to 15 min
T1004	Nurs aide serv, up to 15 min
T1005	Respite care, up to 15 min
T1006	Family/couple counseling
T1007	Treatment plan development
T1009	Child sitting services
T1010	Meals when receive services
T1012	Alcohol/subs abs, skills dev
T1013	Sign lang or oral intrpr serv
T1014	Telehealth transmit, per min
T1016	Case management
T1017	Targeted case management
T1018	School-based IEP ser bundled
T1019	Personal care ser per 15 min
T1020	Personal care ser per diem
T1021	HH aide or CN aide per visit
T1022	Contracted services per day
T1023	Program intake assessment
T1024	Team evaluation & management
T1025	Ped compr care pkg, per diem
T1026	Ped compr care pkg, per hour
T1027	Family training & counseling
T1028	Home environment assessment
T1029	Dwelling lead investigation
T1030	RN home care per diem
T1031	LPN home care per diem
T1502	Medication admin visit
T1503	Med admin other than oral

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
T1999	NOC retail items andsupplies
T2001	N-et; patient attend/escort
T2002	N-et; per diem
T2003	N-et; encounter/trip
T2004	N-et; commerc carrier, pass
T2005	N-et; stretcher van
T2007	Non-emer transport wait time
T2010	PASRR LEVEL I
T2011	PASRR LEVEL II
T2012	Habil ed waiver, per diem
T2013	Habil ed waiver per hour
T2014	Habil prevoc waiver, per d
T2015	Habil prevoc waiver per hr
T2016	Habil res waiver per diem
T2017	Habil res waiver 15 min
T2018	Habil sup empl waiver/diem
T2019	Habil sup empl waiver 15min
T2020	Day habil waiver per diem
T2021	Day habil waiver per 15 min
T2022	Case management, per month
T2023	Targeted case mgmt per month
T2024	Serv asmnt/care plan waiver
T2025	Waiver service, nos
T2026	Special childcare waiver/d
T2027	Spec childcare waiver 15 min
T2028	Special supply, nos waiver
T2029	Special med equip, noswaiver
T2030	Assist living waiver/month
T2031	Assist living waiver/diem
T2032	Res care, nos waiver/month
T2033	Res, nos waiver per diem
T2034	Crisis interven waiver/diem
T2035	Utility services waiver
T2036	Camp overnite waiver/session
T2037	Camp day waiver/session
T2038	Comm trans waiver/service
T2039	Vehicle mod waiver/service
T2040	Financial mgt waiver/15min
T2041	Support broker waiver/15 min
T2042	Hospice routine home care
T2043	Hospice continuous home care
T2044	Hospice respite care
T2045	Hospice general care

Non-Covered HCPCS Codes	
Code	**Abbreviated Description**
T2046	Hospice long term care, r&b
T2048	Bh ltc res r&b, per diem
T2049	N-ET; stretcher van, mileage
T2101	Breast milk proc/store/dist
T4529	Ped size brief/diaper sm/med
T4530	Ped size brief/diaper lg
T4531	Ped size pull-on sm/med
T4532	Ped size pull-on lg
T4538	Diaper serv reusable diaper
T4543	Disp bariatric brief/diaper
T5001	Special position seat/vehicl
T5999	Supply, nos
V2788	Presbyopia-correct function
V5090	Hearing aid dispensing fee
V5095	Implant mid ear hearing pros
V5110	Hearing aid dispensing fee
V5262	Hearing aid, disp, monaural
V5263	Hearing aid, disp, binaural
V5265	Ear mold/insert, disp
V5268	ALD Telephone Amplifier
V5269	Alerting device, any type
V5270	ALD, TV amplifier, any type
V5271	ALD, TV caption decoder
V5272	Tdd
V5273	ALD for cochlear implant
V5274	ALD unspecified
V5275	Ear impression
V5298	Hearing aid noc
V5299	Hearing service

NON-COVERED MODIFIERS

All five-digit CPT® modifiers (e.g. 09951)

–AJ Clinical Social Worker

–Q6 Locum Tenens

–SU Procedure Performed in Physician's Office (to denote use of facility and equipment)

APPENDIX E
MODIFIERS THAT AFFECT PAYMENT

Only modifiers that affect payment are listed in this section. Refer to current CPT® and HCPCS books for complete modifier descriptions and instructions.

CPT® MODIFIERS

–22 Unusual services
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

–24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

–25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure
Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less. Refer to the Professional Services section for information on the use of modifier –25.

–26 Professional component
Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the –26 nor the –TC modifier should be used.

–50 Bilateral surgery
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier –50 should be applied to the second line item.

–51 Multiple surgery
For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

–52 Reduced services
Payment is made at the fee schedule level or billed charge, whichever is less.

–53 Discontinued services
CMS has established reduced RVUs for CPT® code 45378 when billed with modifier –53. L&I prices this code-modifier combination according to those RVUs.

–54 Surgical care only [(1)]
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management.

–55 Postoperative management only [(1)]
When one physician performs the postoperative management and another physician has performed the surgical procedure.

–56 Preoperative management only [(1)]

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

(1) **When providing less than the global surgical package providers should use modifiers –54, –55, and –56.** These modifiers are designed to ensure that the sum of all allowances for all providers does not exceed the total allowance for the global surgery period. These modifiers allow direct payment to the provider of each portion of the global surgery services.

–57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow-up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period) unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

–62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases.

–66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties, other highly skilled, specially trained personnel, and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation is required for this review.

–78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

–80 Assistant surgeon [(2)]

–81 Minimum assistant surgeon [(2)]

–82 Assistant surgeon (when qualified resident surgeon not available) [(2)]

(2) **Assistant Surgeon Modifiers**. Physicians who assist the primary physician in surgery should use modifiers –80, –81 or –82 depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the Professional Services Fee Schedule to determine if assistant surgeon fees are payable.

–91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)

Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test do not qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

–99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only modifier –99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

HCPCS MODIFIERS

–GT Teleconsultations via interactive audio and video telecommunication systems
Payment policies for teleconsultations are located in the Professional Services section.

–LT Left side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–NU New Purchased DME
Use the –NU modifier when a new DME item is to be purchased.

–RR Rented DME
Use the –RR modifier when DME is to be rented.

–RT Right side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

–SG Ambulatory surgical center (ASC) facility service
Bill the appropriate CPT® surgical code(s) adding this modifier –SG to each surgery code.

–TC Technical component
Certain procedures are a combination of the professional (–26) and technical (–TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the –26 nor –TC modifier should be used. Refer to the CPT® modifier section for the use of the –26 modifier.

LOCAL MODIFIER

–1S Surgical dressings for home use
Bill the appropriate HCPCS code for each dressing item using this modifier –1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use.

APPENDIX F
OUTPATIENT DRUG FORMULARY

The following is a list of drugs and therapeutic classes (or class codes) and their status on L&I's outpatient formulary. The formulary may change from time to time to reflect the Washington State Pharmacy and Therapeutics (P&T) Committee's recommendations or administrative changes.

PLEASE NOTE:

- This is an outpatient drug formulary. Many of the drugs not included on the formulary may be appropriate in other settings, such as inpatient, outpatient surgery, emergency room, and clinics or offices, and are covered when billed appropriately.
- Drugs listed on the formulary do not guarantee coverage and may be subject to the department's policy and appropriateness for the accepted conditions.
- Status of the therapeutic classes depends on the drugs' approved indication and is as followed:
  - A = Allowed
  - PA = Prior Authorization required
  - D = Denied
- Drugs that are included in the Washington State's evidence-based Preferred Drug List (PDL) may be subject to the provisions of the Therapeutic Interchange Program (TIP).

State Preferred Drug List

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	D4J	Gastric Acid Secretion Reducer	
		Proton Pump Inhibitors *****Effective May 19, 2008*****	Omeprazole Magnesium (Prilosec OTC) Omeprazole Lansoprazole (Prevacid)
A	H2E	Non-Barbiturate, Sedative-Hypnotics***Acute use only***	
		Benzodiazepine Receptor Agonists	Zolpidem
A	H2S	Serotonin Specific Reuptake Inhibitor (SSRI's)	Citalopram Fluoxetine Paroxetine
A	H3A	Analgesics, Narcotics	
		Long Acting Opioids	Methadone Morphine Sulfate ER/SA
A	H6H	Skeletal Muscle Relaxants	Baclofen Cyclobenzaprine Methocarbamol Tizanidine ****Carisoprodol products are non-covered****
A	H6J	Anti-Emetics	
		5-HT3 Receptor Antagonists	Ondansetron
A	H7B	Alpha-2 Receptor Antagonists	Mirtazapine
A	H7C	Serotonin-Norepinephrine Reuptake Inhib (SNRIs)	Venlafaxine/XR (Effexor XR)
A	H7D	Norepinephrine And Dopamine Reuptake Inhib (NDRIs)	Bupropion/SR

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H7T	Antipsychotic, Atypical Dopamine And Serotonin	Clozapine Risperidone (Risperdal) Quetiapine (Seroquel) Olanzeprine (Zyprexa) Ziprasidone (Geodon)
A	H7X	Antipsychotics, Atypical, D2 Partial Agonist/5HT Mixed	Aripiprazole (Abilify)
A	J5D	Beta Adrenergic Agents (Inhalations)	
		Short Acting Beta Agonists	Albuterol sulfate MDI/nebulizer solution Albuterol sulfate HFA (Ventolin) Levalbuterol HFA/nebulizer solution (Xopenex) Metaproterenol MDI/nebulizer solution
		Long Acting Beta Agonists	Formoterol aerolizer (Foradil) Salmeterol diskus (Serevent)
A	P5A	Glucocorticoids	
		Inhaled Corticosteroids	Beclomethasone MDI (Qvar) Budesonide DPI/nebulizer solution (Pulmicort Respules/Turbuhaler) Flunisolide MDI (Aerobid/Aerobid-M) Fluticasone MDI/DPI (Flovent/Rotadisk/HFA) Mometasone DPI (Asmanex) Triamcinolone MDI (Azmacort)
A	Q7P	Nose Preparations, Anti-inflammatory Steroids	Mometasone (Nasonex) Triamcinolone acetanide (Nasacort AQ)
A	R1A	Urinary Tract Antispasmodic Agents	Oxybutynin IR
A	R1I	Urinary Tract Antispasmodic, M(3) Selective Antagonists	Solifenacin (Vesicare)
A	S2B	NSAIDs, Cyclooxygenase Inhibitors	Diclofenac Potassium/Sodium Etodolac/XL Fenoprofen Flurbiprofen Ibuprofen Indomethacin Ketoprofen Ketorolac Meclofenamate Meloxicam Nabumetone Naproxen/Sodium Piroxicam Oxaprozin Sulindac Tolmetin

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W1D	Macrolides	Azithromycin Clarithromycin/Suspension Erythromycin (Ery-tab 333mg) Erythromycin EC Erythromycin Ethylsuccinate Erythromycin Filmtab Erythromycin Stearate
A	Z2Q	Antihistamines – 2nd Generation	Loratadine OTC

L&I Wrap-around Formulary

Compound Drugs

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	000	Compound Drugs	None

Cardiovascular System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	A1A	Digitalis Glycosides	None
A	A1B	Xanthines	Caffeine Aminophylline Theophylline/SA Theophylline Anhydrous/SR
D	A1C	Inotropic Drugs	None
A	A1D	General Bronchodilator Agents	Ipratropium Bromide
D	A1E	Xanthines & Dietary Supplement Combinations	None
PA	A2A	Antiarrhythmics	None
PA	A2C	Antianginal & Anti-ischemic Agents, Non-hemodynamic	None
PA	A4A	Hypotensives-Vasodilators	None
PA	A4B	Hypotensives-Sympatholytic	None
PA	A4D	Hypotensives-Angiotensin Converting Enzyme Blockers	None
PA	A4F	Hypotensives, Angiotensin Receptor Antagonist	None
PA	A4H	Angiotensin Receptor Antagonist & Calcium Channel Blockers	None
PA	A4I	ACE Inhibitor/Thiazide and Thiazide-like Diuretic Combination	None
PA	A4J	Angiotensin Receptor Antagonist/Thiazide and Thiazide-related Diuretic Combinations	None
PA	A4K	ACE Inhibitor/Calcium Channel Blocker Combination	None
PA	A4T	Renin Inhibitor, Direct	None
PA	A4Y	Hypotensives-Miscellaneous	None
D	A6U	Cardiovascular Diagnostics	None
D	A6V	Cardiovascular Diagnostics – Non Radiopaque	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	A7B	Coronary Vasodilators	None
PA	A7C	Peripheral Vasodilators	None
PA	A7E	Vasodilators-Miscellaneous	None
PA	A7J	Vasodilators, Combination	None
D	A8O	Venosclerosing Agents	None
PA	A9A	Calcium Channel Blocking Agents	None

Respiratory System

Status	TCC	Description	Preferred Drug(s)
A	B0A	Miscellaneous Respiratory Inhalants	Sodium Chloride
D	B1A	Lung Surfactants	None
D	B1B	Pulm Antihypertensive, Endothelin Receptor Antagonist-Type	None
PA	B1C	Pulmonary Antihypertensives, Prostaglandin Type	None
PA	B1D	Pulmonary Antihypertensives, Selective C-GMP Phosphodiesterase T5 Inh.	None
PA	B1E	Pulmonary Antihypertensives, CGMP Pathway, Gases	None
A	B3A	Mucolytics	Acetylcysteine
A	B3J	Expectorants	Guaifenesin
PA	B3K	Cough and Cold Preparations	None
PA	B3N	Decongestant-Analgesic-Expectorant Combination	None
PA	B3O	1st Generation Antihistamine-Decongestant-Analgesic Combination	None
PA	B3P	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic Combination	None
PA	B3Q	Narcotic Antitussive-1st Generation Antihistamine-Decongestant Combination	None
PA	B3R	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant Combination	None
PA	B3S	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant Expectorant Combination	None
PA	B3T	Non-narcotic Antitussive and Expectorant Combination	None
PA	B3V	1st Generation Antihistamine-Decongestant-Analgesic-Expectorant Combination	None
PA	B3X	1st Generation Antihistamine-Decongestant-Anticholinergic Combination	None
PA	B3Y	1st Generation Antihistamine-Decongestant-Analgesic-Expectorant Combination	None
PA	B4A	Non-narcotic Antitussive-Analgsic Combination	None
PA	B4C	Narcotic Antitussive-Anticholinergic Combination	None
PA	B4D	Narcotic Antitussive-1st Generation Antihistamine Combination	None
A	B4E	Non-narcotic Antitussive-1st Generation Antihistamine Combination	Promethazine/Dextromethorphan
PA	B4G	Non-narcotic Antitussive-1st Generation Antihistamine-Analgesic Combination	None

Status	TCC	Description	Preferred Drug(s)
PA	B4H	Narcotic Antitussive-1st Generation Antihistamine-Expectorant Combination	None
PA	B4I	Non-narcotic Antitussive-1st Generation Antihistamine-Expectorant Combination	None
PA	B4J	Narcotic Antitussive-1st Generation Antihistamine-Decongestant-Expectorant Combination	None
PA	B4K	Narcotic Antitussive-Decongestant Combination	None
PA	B4L	Non-narcotic Antitussive-Decongestant	None
PA	B4M	Non-narcotic Antitussive-Decongestant-Analgesic Combination	None
PA	B4N	Narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic Combination	None
PA	B4P	Non-narcotic Antitussive-1st Generation Antihistamine-Analgesic-Expectorant Combination	None
PA	B4Q	Narcotic Antitussive-Decongestant-Expectorant Combination	None
PA	B4R	Non-narcotic Antitussive-Decongestant-Expectorant Combination	None
PA	B4S	Narcotic Antitussive-Expectorant Combination	None
PA	B4T	Decongestant-Analgesic, Non-salicylate Combination	None
PA	B4U	Decongestant-Anticholinergic Combination	None
A	B4W	Decongestant-Expectorant Combination	Guaifenesin/Pseudoephedrine Guaifenesin/Phenylpropanolamine
PA	B4X	Expectorant Combination, Other	None
PA	B5E	Decongestant-Analgesic, Mixed-Xanthine Combination	None
PA	B5F	Decongestant-Analgesics, Salicylate Combination	None
PA	B5G	Decongestant-NSAID, COX Non-specific Combination	None
PA	B5H	1st Generation Antihistamine-Decongestant-NSAID, COX Non-specific Combination	None
PA	B5K	Decongestant-Analgesic, Salicylate-Xanthine Combination	None
PA	B5J	Decongestant-Analgesic, Non-salicylate-Xanthine Combination	None
PA	B5M	1st Generation Antihistamine-Decongestant-Analgesic, Mixed	None
PA	B5N	1st Generation Antihistamine-Decongestant-Analgesic, Salicylate	None
PA	B5P	Decongestant-Analgesic, Salicylate-Expectorant Combination	None
PA	B5Q	Non-narcotic Antitussive-1st Generation Antihistamine-Decongestant-Analgesic, Salicylate Combination	None
PA	B5S	1st Generation Antihistamine-Analgesic, Non-salicylate Combination	None
PA	B5T	1st Generation Antihistamine-Anticholinergic Combination	None
PA	B5Y	Analgesic, Non-Salicylate – 1st Generation Antihistamine - Xanthine	None

Status	TCC	Description	Preferred Drug(s)
D	B6D	Decongestant-Expectorant with Zinc Combination	None

Electrolyte Balancing Sys/Metabolic Sys/Nutrition

Status	TCC	Description	Preferred Drug(s)
PA	C0B	Water	None
D	C0C	Drugs Used To Treat Acidosis	None
PA	C0D	Antialcoholic Preparations	None
PA	C0K	Bicarbonate Producing/Containing Agents	None
PA	C1A	Electrolyte Depleters	None
PA	C1B	Sodium Replacement	None
PA	C1D	Potassium Replacement	None
PA	C1F	Calcium Replacement	None
PA	C1H	Magnesium Replacement	None
D	C1K	Cardioplegic Solutions	None
PA	C1P	Phosphate Replacement	None
PA	C1W	Electrolyte Replacement	None
D	C2H	Respiratory Gases	None
PA	C3B	Iron Replacement	None
PA	C3C	Zinc Replacement	None
PA	C3H	Iodine Replacement	None
PA	C3M	Miscellaneous Mineral Replacement	None
PA	C4F	Antihyperglycemic, (DPP-4) Enzyme Inhibitor & Biguanide Type (N-S) Combination	None
PA	C4G	Insulins	None
PA	C4J	Antihyperglycemic, DPP-4 Inhibitors	None
PA	C4K	Hypoglycemics, Insulin-Release Stim. Type	None
PA	C4L	Hypoglycemics, Biguanide Type (N-S)	None
PA	C4M	Hypoglycemics, Alpha-Glucosidase Inhibitor Type (N-S)	None
PA	C4N	Hypoglycemics, Insulin-Response Enhancer (N-S)	None
PA	C4Q	Hypoglycemics, Combination	None
PA	C4R	Hypoglycemics, Insulin-Response & Insulin Release Combinations	None
PA	C4S	Hypoglycemics, Insulin-Release Stimulant & Biguanide (N-S) Combinations	None
PA	C4T	Hypoglycemics, Insulin-Response Enhancer & Biguanide Type (N-S) Combinations	None
D	C4U	Hypoglycemics, Biguanide Type & Dietary Supplement Combinations	None
PA	C5A	Carbohydrates	None
PA	C5B	Protein Replacement	None
D	C5C	Infant Formulas	None
D	C5D	Diet Foods	None
D	C5F	Miscellaneous Food Supplements	None
D	C5G	Food Oils	None
PA	C5J	IV Solutions: Dextrose/Water	None
PA	C5K	IV Solutions: Dextrose/Saline	None
PA	C5L	IV Solutions: Dextrose/Ringers	None
PA	C5M	IV Solutions: Dextrose/Lactated Ringers	None
PA	C5O	Solutions, Miscellaneous	None

Status	TCC	Description	Preferred Drug(s)
D	C5X	Nutritional Therapy, Phenylketonuria (PKU) Formulation	None
D	C5U	Nutritional Therapy, Glucose Intolerance Formulation	None
D	C6A	Vitamin A Preparations	None
D	C6B	Vitamin B Preparations	None
PA	C6C	Vitamin C Preparations	None
D	C6D	Vitamin D Preparations	None
D	C6E	Vitamin E Preparations	None
D	C6F	Prenatal Vitamin Preparations	None
D	C6G	Geriatric Vitamin Preparations	None
D	C6H	Pediatric Vitamin Preparations	None
D	C6I	Antioxidant Multivitamin Combinations	None
D	C6J	Bioflavonoids	None
PA	C6K	Vitamin K Preparations	None
PA	C6L	Vitamin B12 Preparations	None
PA	C6M	Folic Acid Preparations	None
D	C6N	Niacin Preparations	None
D	C6P	Panthenol Preparations	None
D	C6Q	Vitamin B6 Preparations	None
D	C6R	Vitamin B2 Preparations	None
D	C6T	Vitamin B1 Preparations	None
D	C6Z	Miscellaneous Multivitamin Preparations	None
D	C7A	Purine Inhibitors	None
D	C7D	Metabolic Deficiency Agents	None
PA	C7F	Appetite Stimulants for Anorexia, Cachexia, Wasting Syndrome	None
D	C7G	Hyperuricemia Treatments – Urate-Oxidase Enzyme-Type	None
A	C8A	Metallic Poison Antidotes	All
A	C8B	Acid And Alkali Poison Antidotes	All
A	C8E	Miscellaneous Antidotes	All

Biliary System/Gastro-Intestinal System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	D0U	Gastrointestinal Radiopaque Diagnostics	None
PA	D1D	Dental Aids & Preparations	None
PA	D1E	Periodontal Tetracycline Anti-infective, Local	None
D	D2A	Fluoride Preparations	None
D	D2D	Tooth Ache Preparations	None
A	D4A	Acid Replacement	All
A	D4B	Antacids	Sodium Bicarbonate Aluminum Hydroxide Antacid/Simethicone Calcium Carbonate
A	D4D	Antidiarrheal Microorganisms Agents	All
A	D4E	Antiulcer Preparations	Misoprostol Sucralfate
D	D4F	Antiulcer -- H. Pylori Agents	None
A	D4G	Gastric Enzymes	Lactaid Ultra
A	D4H	Oral Mucositis/Stomatitis Agents	All

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	D4I	Oral Mucositis/Stomatitis Antiinflammatory Agents	All
A	D4N	Antiflatulents	All
D	D4O	Gastrointestinal Ultrasnd Image Enhancing Adjnct, Diag	None
A	D4Q	Digestive Agents, Other	All
A	D5P	Intestinal Adsorbents And Protectives	All
PA	D6A	Drugs To Treat Chronic Inflammatory Diseases Of The Colon	None
D	D6C	Irritable Bowel Syndrome Agent, 5HT-3 Antagonist-Type	None
A	D6D	Antidiarrheals	All
D	D6E	Irritable Bowel Syndrome Agents, 5HT-4 Partial Agonist	None
PA	D6F	Drugs To Treat Chronic Inflammatory Colon Dx 5 – Aminosalicyl	None
A	D6H	Hemorrhoidal Agents	All
A	D6S	Laxatives And Cathartics	All
A	D7A	Bile Salts	All
A	D7B	Choleretics	All
D	D7C	Hepatic Diagnostics	None
D	D7D	Drugs To Treat Hereditary Tyrosinemia	None
PA	D7J	Hepatic Dysfunction Preventive/ Therapy Agents	None
A	D7L	Bile Salt Inhibitors	Cholestyramine/Light Colestipol (Colestid) Colesevelam (Welchol)
D	D7T	Biliary Diagnostics	None
D	D7U	Biliary Diagnostics, Radiopaque	None
A	D8A	Pancreatic Enzymes	Cotazym Creon 10 Creon 20 Creon 5 Pancrelipase
A	D9A	Ammonia Inhibitors	Lactulose

Male Genital System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	F1A	Androgenic Agents	None
PA	F2A	Drugs To Treat Impotency	None

Female Genital System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	G0U	Uterine Radiopaque Diagnostic Agents	None
D	G1A	Estrogenic Agents	None
D	G1B	Estrogen/Androgen Combination Preparations	None
D	G2A	Progestational Agents	None
D	G3A	Oxytocics	None
D	G8A	Contraceptives, Oral	None
D	G8B	Contraceptives, Implantable	None
D	G8C	Contraceptives, Injectable	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	G8D	Abortifacient, Progesterone Receptor Antagonist Type	None
D	G8F	Contraceptives, Transdermal	None
D	G9A	Contraceptives, Intravaginal	None
D	G9B	Contraceptives, Intravaginal, Systemic	None

Nervous System (Except Autonomic)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H0A	Local Anesthetics	Cepacol
D	H0E	Agents To Treat Multiple Sclerosis	None
D	H0F	Agents To Treat Neuromusc Transmission Dis, Potassium Channel Blocker Type	None
D	H1A	Alzheimer's Tx, N-Methyl-D-Aspart (NMDA) Recept Antags	None
D	H1U	Cerebral Spinal Radiopaque Diagnostics	None
PA	H2A	Central Nervous System Stimulants	None
D	H2B	General Anesthetics, Inhalant	None
D	H2C	General Anesthetics, Injectable	None
A	H2D	Barbiturates (Phenobarbital Only)	Phenobarbital
A	H2E	Non-Barbiturate, Sedative-Hypnotics ***Acute use only***	Chloral Hydrate Estazolam Diphenhydramine Flurazepam Temazepam Triazolam
		Benzodiazepines & Others	
A	H2F	Antianxiety Drugs	Alprazolam/ER Buspirone Chlordiazepoxide Clorazepate Dipotassium Diazepam Lorazepam Oxazepam
A	H2G	Anti-Psychotics, Phenothiazines	Chlorpromazine Fluphenazine Perphenazine Thioridazine Trifluoperazinel
A	H2H	Monoamine Oxidase (MAO) Inhibitors	Phenelzine Tranylcypromine Isocarboxazid
A	H2M	Anti-Mania Drugs	Lithium Carbonate/CR Lithium Citrate
D	H2T	Alcohol-Systemic Use	None
A	H2U	Tricyclic Antidepressants & Related Non-SRI	Amitriptyline Desipramine Doxepin Imipramine Maprotiline Nortriptyline
PA	H2V	Anti-Narcolepsy/Anti-Hyperkinesis Agents	None
A	H2W	Tricyclic Antidepressant/Phenothiazine Combinations	Amitriptyline/Perphenazine
A	H2X	Tricyclic Antidepressant/Benzodiazepine Combination	Amitriptyline/Chlordiazepoxide

A	H3A	Analgesics, Narcotics	
		Short Acting Opioids	Codeine Sulfate/Phosphate Hydrocodone/Acetaminophen Hydromorphone Meperidine Morphine Sulfate Oxycodone Oxycodone/Acetaminophen Oxycodone/Aspirin Propoxyphene HCL Propoxyphene/Acetaminophen Pentazocine/Naloxone Pentazocine/Acetaminophen Tramadol Tramadol/Acetaminophen
A	H3C	Analgesics, Non-Narcotics	Baclofen (Duraclon)
A	H3D	Salicylate Analgesics	Aspirin Aspirin Buffered Choline Mag Trisalicylate Diflunisal Salsalate
A	H3E	Analgesic/Antipyretics, Non-Salicylate	Acetaminophen
PA	H3F	Antimigraine Preparations	None
D	H3H	Analgesics Narcotic, Anesthetic Adjunct	None
D	H3I	Analgesics, Neuronal-type Calcium Channel Blocker	None
D	H3J	Analgesics Narcotic/Dietary Supplement Combinations	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H3K	Analgesics, Non-salicylate and Barbiturate Combination	Acetaminophen/Butalbital
A	H3L	Analgesics, Non-salicylate, Barbiturate and Xanthine Combination	Acetaminophen/Caffeine/Butalbital
PA	H3M	Narcotic Analgesic, Non-salicylate Analgesic, Barbiturate and Xanthine Combination	None
A	H3N	Analgesics, Narcotics Agonist and NSAIDs, COX Inhibitor-type Combination	Hydrocodone/Ibuprofen
A	H3O	Analgesics, Salicylate, Barbiturate and Xanthine Combination	Aspirin/Caffeine/Butalbital
PA	H3R	Narcotic and Salicylate Analgesics, Barbiturate and Xanthine Combination	None
A	H3T	Narcotic Antagonists	Naloxone
A	H3U	Narcotic Analgesic and Non-salicylate Analgesic Combination	Codeine/Acetaminophen
A	H3V	Analgesics, Salicylate & Non-salicylate Combination	All
A	H4B	Anticonvulsants ****Please see PB 05-10 Antiepileptic Drugs Guideline for Chronic Pain****	Carbamazepine/XR Clonazepam Depakote Diazepam Mephobarbital Gabapentin Phenytoin Sodium ER Primidone Valproic Acid
D	H4D	Anticonvulsant/Dietary Supplement Combinations	None
PA	H6A	Antiparkinsonism Drugs, Other	None
A	H6B	Antiparkinsonism Drugs, Anticholinergic	Benztropine Mesylate Trihexyphenidyl
A	H6C	Antitussive, Non-Narcotic	Benzonatate Dextromethorphan
A	H6E	Emetics	Ipecac
A	H6J	Anti-Emetics	
		Others	Dimenhydrinate Emetrol Meclizine Prochlorperazine Promethazine Thiethylperazine Trimethobenzamide
A	H7E	Serotonin-2 Antagonist/Reuptake Inhib (SARIs)	Trazodone
A	H7J	MAOIs - Non-Selective & Irreversible	All
A	H7O	Antipsychotic, Dopamine Antagonist, Butyrophenones	All
A	H7P	Antipsychotic, Dopamine Antagonist, Thioxanthenes	Thiothixene

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	H7R	Antipsychotic, Dopamine Antagonist, Diphenylbutylpiperidines	Pimozide (Orap)
A	H7S	Antipsychotic, Dopamine And Serotonin Antagonist	Molidone (Moban)
A	H7U	Antipsychotic, Dopamine And Serotonin Antagonist	Loxapine Succinate
D	H7W	Anti-Narcolepsy/Anti-Cataplexy, Sedative-Type Agent	None
PA	H7Y	Tx For Attn Deficit-Hyperactivity Disorder (ADHD), NRI-Type	None
PA	H7Z	SSRI & Antipsych, Atyp, Dopamine & Serotonin Antagonist Combination	None
PA	H8A	Antianxiety, Antispasmodic Combination	None
A	H8B	Hypnotic, Melatonin MT1/MT2 Receptor Agonists	Ramelteon (Rozerem)
D	H8I	Selective Serotonin Reuptake Inhibitor (SSRI)/Dietary Supplement Combinations	None
D	H8J	Norepinephrine and Dopamine Reuptake Inhibitor (NDRI)/Dietary Supplement Combinations	None
D	H8K	Antianxiety Drug/Dietary Supplement Combinations	None

Autonomic Nervous System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	J1A	Parasympathetic Agents	Bethanechol Chloride
PA	J1B	Cholinesterase Inhibitors	None
A	J2A	Belladonna Alkaloids	Belladonna/Phenobarbital Hyoscyamine
A	J2B	Anticholinergics, Quaternary	Clidinium/Chlordiazepoxide Glycopyrrolate Propantheline Bromide
A	J2D	Anticholinergics/Antispasmodics	Dicyclomine
PA	J3A	Smoking Deterrent Agents-Ganglionic Stimulant	None
PA	J3C	Smoking Deterrent-Nicotinic Receptor Partial Agonist	None
D	J5A	Adrenergic Agents, Catecholamines	None
D	J5B	Adrenergics, Aromatic Non-Catecholamines (Amphetamine)	None
A	J5C	Adrenergic Agents, Non-Aromatic	All
A	J5D	Beta-Adrenergic Agents	
		Oral Beta Agonist	Albuterol sulfate/SA Metaproterenol
A	J5E	Sympathomimetic Nasal Decongestants	Oxymetazoline/Methol (Afrin) Ephedrine Sulfate Pseudoephedrine
A	J5F	Anaphylaxis Therapy Agents	Ana-Kit Epipen
A	J5G	Beta-Adrenergics and Glucocorticoids Combination	Fluticasone/Salmeterol (Advair Diskus)
A	J5H	Adrenergic Vasopressor Agents	Midodrine HCl

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	J5J	Beta Adrenergic and Anticholinergic Combination	Albuterol/Ipratropium MDI/Nebulizer Solution
PA	J7A	Alpha/Beta Adrenergic Blocking Agents	None
A	J7B	Alpha-Adrenergic Blocking Agents	Doxazosin Mesylate Prazosin Terazosin
PA	J7C	Beta-Adrenergic Blocking Agents	None
PA	J7E	Alpha-Adrenergic Blocking Agent/ Thiazide Combination	None
D	J7G	Beta Adrenergic Agent/Dietary Supplement Combinations	None
D	J8A	Anorexic Agents	None
D	J8B	Cannabinoid-1 Receptor (CB1) Antagonist	None
A	J9A	Intestinal Motility Stimulants	Metoclopramide
PA	J9B	Antispasmodic Agents	None

Skin/Subcutaneous Tissue

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	L0B	Topical/Mucous Membrane/Sub-Q Enzyme Preps	Collagenase (Santyl)
PA	L1A	Antipsoriatic Agents, Systemic	None
D	L1B	Acne Agents, Systemic	None
A	L2A	Emollients	All
A	L3A	Protectives	All
A	L3P	Antipruritics, Topical	Calamine/Pamoxine (Caladryl) Diphenhydramine
A	L4A	Astringents	All
D	L5A	Keratolytics	None
D	L5B	Sunscreens	None
D	L5C	Abrasives	None
D	L5E	Antiseborrheic Agents	None
PA	L5F	Antipsoriatic Agents, Topical	None
D	L5G	Rosacea Agents, Topical	None
D	L5H	Acne Agents, Topical	None
A	L5I	Wound Healing Agents, Local	Hyalofill-F Peviderm Wound Care Solution
A	L6A	Irritants/Counter-Irritants	All
D	L7A	Shampoos	None
D	L8A	Deodorants	None
D	L8B	Antiperspirants	None
A	L9A	Miscellaneous Topical Agents	All
D	L9B	Vitamin A Derivatives	None
D	L9C	Hypopigmentation Agents	None
D	L9D	Topical Hyperpigmentation Agents	None
D	L9F	Cosmetic/Skin Coloring/Dye Agents, Topical	None
D	L9G	Skin Tissue Replacement	None
D	L9I	Vitamin A Derivatives, Topical Cosmetic Agents	None

Blood

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	M0B	Plasma Proteins	None
PA	M0D	Plasma Expanders	None
PA	M0E	Antihemophilic Factors	None
PA	M0F	Factor IX Preparations	None
D	M0L	Human Monoclonal Antibody Complement (C5) Inhibitors	None
PA	M0M	Protein C Preparations	None
A	M3A	Occult Blood Tests	All
PA	M4A	Blood Sugar Diagnostics	None
PA	M4B	IV Fat Emulsions	None
D	M4E	Lipotropics	None
D	M4G	Hyperglycemics	None
D	M4I	Antihyperlipid (HMG CoA) & Calcium Channel Blocker	None
PA	M9A	Topical Hemostatics	None
PA	M9D	Antifibrinolytic Agents	None
PA	M9E	Thrombin Inhibitors, Hirudin Type Agents	None
PA	M9F	Thrombolytic Enzymes	None
PA	M9J	Citrates As Anticoagulants	None
PA	M9K	Heparin Preparations	None
A	M9L	Oral Anticoagulants, Coumarin Type	Warfarin Sodium
PA	M9P	Platelet Aggregation Inhibitors	None

Bone Marrow

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	N1B	Hematinics, Other	None
D	N1C	Leukocyte (WBC) Stimulants	None
PA	N1D	Platelet Reducing Agents	None

Endocrine System (Except Gonads)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	P0B	Follicle Stimulating Hormones	None
D	P1A	Growth Hormones	None
D	P1B	Somatostatic Agents	None
D	P1E	Adrenocorticotrophic Hormones	None
D	P1F	Pituitary Suppressive Agents	None
D	P1H	Growth Hormone Releasing Hormone	None
D	P1L	Luteinizing Hormone Releasing-Hormone	None
D	P1M	LHRH/GNRH Agonist Analog Pituitary Suppressants	None
D	P1N	LHRH Antagonist Pituitary Suppressant Agents	None
D	P1P	LHRH/GNRH Agonist Pituitary Suppressants-C Prec Puberty	None
D	P1Q	Growth Hormone Receptor Antagonists	None
D	P1U	Metabolic Function Diagnostics	None
D	P2B	Antidiuretic And Vasopressor Hormones	None
D	P3A	Thyroid Hormones	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	P3B	Thyroid Function Diagnostic Agents	None
D	P3L	Antithyroid Preparations	None
D	P4B	Bone Formation Stimulating Agents – Parathyroid Hormone	None
D	P4D	Hyperparathyroid Treatment Agents – Vitamin D Analog-Type	None
PA	P4E	Bone Morphogenic Agents	None
PA	P4L	Bone Resorption Suppression Agents	None
D	P4M	Calcimimetic, Parathyroid Calcium Enhancer	None
A	P5A	Glucocorticoids	
		Oral Corticosteroids	Betamethasone Cortisone Acetate Dexamethasone Hydrocortisone Methylprednisolone Prednisolone Prednisone
A	P5S	Mineralocorticoids	Fludrocortisone Acetate
D	P6A	Pineal Hormone Agents	None

Ear, Eye, Nose, Rectum, Topical, Vagina, Spec Senses

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	Q2D	Ophth Vascular Endothelial Growth Factor Antagonist	None
D	Q2U	Eye Diagnostic Agents	None
A	Q3A	Rectal Preparations	Hydrocortisone Acetate Hydrocortisone/Pramoxine (Proctofoam-HC)
A	Q3B	Rectal/Lower Bowel Prep, Glucocorticoid, Non-Hemorrhoidal	All
A	Q3D	Hemorrhoidal Preparations	Benzocaine/Benzethonium (Americaine Hemorrhoidal) Hydrocortisone/Pamoxine (Analpram-HC) Phenylephrine Hydrocortisone Acetate (Anusol HC) Pramoxine (Tronolane)
PA	Q3E	Chronic Inflm Colon Dx 5 - Aminosalicylates	None
A	Q3H	Hemorrhoidal Preparations, Local Anesthetics	Dibucaine
A	Q3S	Laxatives, Local/Rectal	All
PA	Q4A	Vaginal Preparations	None
PA	Q4B	Vaginal Antiseptics	None
PA	Q4F	Vaginal Antifungals	None
PA	Q4H	Vaginal/Cervical Care and Treatment Agents	None
D	Q4K	Vaginal Estrogen Preparations	None
PA	Q4S	Vaginal Sulfonamides	None
PA	Q4W	Vaginal Antibiotics	None
D	Q5A	Topical Preparations, Miscellaneous	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q5B	Topical Preparations, Antibacterials	Betadine Boric Acid Cetaphil Chlorhexidine Gluconate Clioquinol/Hydrocortisone Iodochlorhydroxyquin/HC Povidone-Iodine Silver Nitrate Zephiran Chloride
D	Q5C	Topical Preparations, Hypertrichotic Agents	None
A	Q5E	Topical Antiinflammatory, Non-Steroidal	All
PA	Q5F	Topical Antifungals	None
A	Q5H	Topical Local Anesthetics	Benzocaine Cetacaine Dibucaine Ethyl Chloride Lidocaine (NOT Lidoderm) Pramoxine Benzocaine/Triclosan Benzocaine/Resorcinal Xylocaine
A	Q5K	Topical Immunosuppressive Agents	Primecolimus (Elidel)
PA	Q5N	Topical Antineoplastics	None
A	Q5P	Topical Antiinflammatory Preparations	Amcinonide Betamethasone Dipropionate Betamethasone Valerate Clobetasol Propionate Desonide Desoximetasone Diflorasone Diacetate Triamcinolone Acetonide Embeline Fluocinolone Acetonide Fluocinonide Hydrocortisone Mometasone Furoate
A	Q5R	Topical Antiparasitics	Cromtamiton (Eurax) Permethrin
A	Q5S	Topical Sulfonamides	Silver Sulfadiazine Sodium Sulfacetamide/Sulfur
PA	Q5V	Topical Antivirals	None
A	Q5W	Topical Antibiotics	All
A	Q5X	Topical Antibiotics/Antiinflammatory, Steroidal	Neomycin/Hydrocortisone
A	Q6A	Eye Preparations, Miscellaneous	All
A	Q6C	Eye Vasoconstrictors (Rx Only)	All
A	Q6D	Eye Vasoconstrictors (OTC Only)	All
A	Q6E	Eye Irrigations	All

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q6G	Miotics And Other Intraocular Pressure Reducers	Brinzolamide (Azopt) Betaxolol Brimonidine Tartrate Carteolol Timolol/Dorzolamide (Cosopt) Carbachol Levobunolol Metipranolol P1E1 P2E1 P4E1 P6E1 Phospholine Iodide Pilocarpine Timolol Maleate Dorzolamide (Trusopt) Latanoprost (Xalatan)
A	Q6H	Eye Local Anesthetics	None
A	Q6I	Eye Antibiotic-Corticoid Combinations	All
PA	Q6J	Mydriatics	None
A	Q6P	Eye Antiinflammatory Agents	Dexamethasone Sod Phosphate Diclofenac Sodium Fluorometholone Flurbiprofen Sodium HMS Loteprednol (Lotemax) Prednisolone Acetate
A	Q6R	Eye Antihistamines	Levocarbastine (Livostin) Olopatadine (Patanol) Ketotifen (Zaditor)
A	Q6S	Eye Sulfonamides	Sulfacetamide Sodium Sulfacetamide/Prednisolone
A	Q6T	Artificial Tears	All
PA	Q6U	Ophthalmic Mast Cell Stabilizers	None
PA	Q6V	Eye Antivirals	None
A	Q6W	Eye Antibiotics	Bacitracin Bacitracin/Polymyxin Chloramphenicol Ciprofloxacin Erythromycin Gentamicin Sulfate Neomycin/Bacitracin/Polymyxin Ofloxacin Polymyxin B Sulfate/Trimethoprim Tobramycin Sulfate Gatifloxacin (Zymar)
A	Q6Y	Eye Preparations, Miscellaneous (OTC Only)	All
A	Q7A	Nose Preparations, Miscellaneous (Rx Only)	Ipratropium Bromide
A	Q7C	Nose Preparations, Vasoconstrictors (Rx Only)	All
A	Q7D	Nose Preparations, Vasoconstrictors (OTC Only)	All
A	Q7E	Nasal Antihistamine	Azelastine (Astelin)
A	Q7W	Nose Preparations, Antibiotics	Mupirocine (Bactroban Nasal)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	Q7Y	Nose Preparations, Miscellaneous (Otc Only)	All
A	Q8B	Ear Preparations, Miscellaneous Antiinfectives	Acetasol Acetic Acid Acetic Acid/Hydrocortisone
PA	Q8C	Otic, Antiinfective-Local Anesthetic Combinations	None
A	Q8F	Ear Preparations, Anti-Inflammatory-Antibiotics	Ciprofloxacin/Hydrocortisone (Cipro HC)
A	Q8H	Ear Preparations, Local Anesthetics	Antipyrine/Benzocaine
D	Q8R	Ear Preparations, Ear Wax Removers	None
A	Q8W	Ear Preparations, Antibiotics ****Effective January 1, 2007****	Neomycin/Polymyxin/HC
A	Q8Y	Ear Preparations, Miscellaneous (OTC Only)	All
D	Q9B	Benign Prostatic Hypertrophy/ Micturition Agents	None

Kidney/Urinary Tract

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	R1B	Osmotic Diuretics	None
PA	R1E	Carbonic Anhydrase Inhibitors	None
PA	R1F	Thiazide Diuretics And Related Agents	None
PA	R1H	Potassium Sparing Diuretics	None
PA	R1K	Miscellaneous Diuretics	None
PA	R1L	Potassium Sparing Diuretics In Combination	None
PA	R1M	Loop Diuretics	None
PA	R1N	Arginine Vasopressin (AVP) Receptor Antagonists	None
D	R1R	Uricosuric Agents	None
A	R1S	Urinary Ph Modifiers	Potassium Citrate/Sodium Citrate (Citrolith) Potassium Phosphate Monobasic (K-Phos Original) Potassium Citrate/Citric Acid Renacidin Sodium Citrate & Citric Acid Potassium Citrate (Urocit-K)
D	R1U	Renal Function Diagnostic Agents	None
D	R2U	Urinary Tract Radiopaque Diagnostics	None
PA	R3D	Drug Detection Tests, Urine	None
PA	R3U	Urine Glucose Test Aids	None
PA	R3V	Miscellaneous Urine Test Aids	None
PA	R3W	Urine Acetone Test Aids	None
PA	R3Y	Urine Multiple Test Aids	None
PA	R4A	Kidney Stone Agents	None
PA	R5A	Urinary Tract Anesthetic/Analgesic Agents	None

Locomotor System

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	S2A	Colchicine	None
PA	S2C	Gold Salts	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	S2H	Anti-Inflammatory/Antiarthritic Agents, Miscellaneous	None
PA	S2I	Anti-Inflammatory, Pyrimidine Synthesis Inhibitor	None
PA	S2J	Anti-Inflammatory, Tumor Necrosis Factor Inhibitor	None
PA	S2P	NSAIDs, Cyclooxygenase 2 Inhibitor-Type & Proton Pump Inhib Comb	None
PA	S2Q	Anti-inflammatory, Selective Costim. Mod., T-Cell Inhibitors	None
D	S2R	NSAIDs (Nonsteroidal Anti-inflammatory Drugs) Cyclooxygenase Inhibitor/Dietary Supplement Combination	None
D	S2S	Analgesic, NSAID COX Type-1st Generation Antihistamine, Sedative Combination	None
D	S7A	Neuromuscular Blocking Agents	None

Ear, Eye, Nose, Rectum, Topical, Vagina, Spec Senses (CONT.)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	T0A	Topical Vit D Analog/Antiinflammatory Steroidal	None
PA	T0B	Topical Pleuromutilin Derivatives	None
D	T0C	Topical Genital Wart-HPV Treatment Agent	None

Miscellaneous Drugs and Pharmaceutical Adjuvants

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	U5A	Homeopathic Drugs	None
D	U5B	Herbal Drugs	None
D	U5F	Animal/Human Derived Agents	None
A	U6A	Pharmaceutical Adjuvants, Tableting Agents	All
A	U6B	Pharmaceutical Adjuvants, Coating Agents	All
A	U6C	Thickening Agents	All
A	U6F	Hydrophilic Cream/Ointment Bases	All
A	U6H	Solvents	All
A	U6N	Vehicles	All
A	U6S	Propellants	All
PA	U6W	Bulk Chemicals, O.U.	None
A	U7A	Suspending Agents	All
A	U7D	Surfactants	All
A	U7H	Antioxidants	All
A	U7K	Flavoring Agents	All
A	U7N	Sweeteners	All
A	U7P	Perfumes	All
A	U7Q	Coloring Agents	All

Neoplasms

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	V1A	Alkylating Agents	None
PA	V1B	Antimetabolites	None
PA	V1C	Vinca Alkaloids	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
PA	V1D	Antibiotic Antineoplastics	None
PA	V1E	Steroid Antineoplastics	None
PA	V1F	Miscellaneous Antineoplastics	None
PA	V1I	Chemotherapy Antidotes	None
PA	V1J	Antiandrogenic Agents	None
PA	V1K	Antineoplastics Antibody/Antibody-Drug Complexes	None
PA	V1M	Antineoplastics Immunomodulator Agents	None
D	V1O	Antineoplastic Lhrh Agonists, Pituitary Suppressant	None
PA	V1Q	Antineoplastic Systemic Enzyme Inhibitor	None
PA	V1R	Photoactivated, Antineoplastic Agents, Systemic	None
PA	V1T	Selective Estrogen Receptor Modulators (Serm)	None
D	V1V	Antineoplastic LHRH (GNRH) Antagonist, Pitiutary Suppressors	None
PA	V1W	Antineoplastic EGF Recceptor Blocker RCMB MC Antibody	None
PA	V1X	Antineoplastic Hum VEGF Inhibitor RCMB MC Antibody	None
PA	V3A	Antineoplastic Histone Deacetylase Inhibitors (HDIs, HDACIs)	None
PA	V3C	Antineoplastic – MTOR Kinase Inhibitors	None
PA	V3D	Antineoplastic – Epothilones and Analogs	None

Anti-Infecting Agents

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W1A	Penicillins	Amoxicillin Trihydrate/Potassium Claulanate Amoxicillin Ampicillin Dicloxacillin Sodium Penicillin V Potassium
A	W1C	Tetracyclines	Doxycycline Minocycline Tetracycline
A	W1E	Chloramphenicol and Derivatives	All
A	W1F	Aminoglycosides	All
A	W1G	Antitubercular Antibiotics	Rifampin
A	W1J	Vancomycin And Derivatives	Vancomycin oral
A	W1K	Lincosamides	Clindamycin Lincomycin
A	W1L	Topical Antibiotics	All
A	W1M	Streptogramins	All
A	W1N	Polymyxin And Derivatives	Colistimethate Sodium Polymyxin B Sulfate
A	W1O	Oxazolidones	Linezolid (Zyvox)
A	W1P	Oxabeta-Lactams	All
A	W1Q	Quinolones	Moxifloxacin (Avelox) Ciprofloxacin Levofloxacin (Levaquin) Ofloxacin Gatifloxacin (Tequin)

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W1S	Carbapenems (Thienamycins)	All
A	W1W	Cephalosporins-1st Generation	Cefadroxil Cephalexin
A	W1X	Cephalosporins-2nd Generation	Cefaclor Cefuroxime Axetil Cefprozil (Cefzil)
A	W1Y	Cephalosporins-3rd Generation	Cefixime (Suprax) Cefditoren (Spectracef)
A	W1Z	Cephalosporins-4th Generation	All
A	W2A	Absorbable Sulfonamides	Sulfadiazine Sulfamethoxazole/Trimethoprim Sulfisoxazole
A	W2E	Antitubercular Agents	Ethambutol Isoniazid Pyrazinamide
A	W2F	Nitrofuran Derivatives	Nitrofurantoin Macrocrystal Nitrofurantoin
A	W2G	Antibacterial Chemotherapeutic Agents, Misc.	Methenamine Mandelate Trimethoprim Urinary Antiseptic
A	W2Y	Miscellaneous Antiinfectives	All
A	W3A	Antifungal Antibiotics	Griseofluvin Ultramicroside Nystatin
A	W3B	Antifungal Agents	Ketoconazole Clotrimazole Fluconazole Terbinafine (Lamisil) Itraconazole Voriconazole (Vfend)
A	W4A	Antimalarial Drugs	Chloroquine Phosphate Pyrimethamine (Daraprim) Pyrimethamine/Sulfadoxine (Fansidar) Halofantrine (Halfan) Hydroxychloroquine Sulfate Atovaquone/Proguanil (Malarone) Mefloquine Primaquine Quinine Sulfate
D	W4C	Amebacides	None
A	W4E	Trichomonacides	Metronidazole
D	W4K	Miscellaneous Antiprotozoal Drugs	None
D	W4L	Anthelmintics	None
D	W4M	Topical Antiparasitics	None
D	W4P	Antileprotics	None
D	W4Q	Insecticides	None
PA	W5A	Antivirals	None
A	W5C	Antivirals, HIV-Specific, Protease Inhibitors	All
PA	W5D	Antiviral Monoclonal Antibodies	None
PA	W5E	Hepatitis A Treatment Agents	None
PA	W5F	Hepatitis B Treatment Agents	None
PA	W5G	Hepatitis C Treatment Agents	None
A	W5I	Antivirals, HIV-Spec, Nucleotide Analog, RTIs	All

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
A	W5J	Antivirals, HIV-Spec, Nucleoside Analog, RTIs	All
A	W5K	Antivirals, HIV-Spec, Non-Nucleoside RTIs	All
A	W5L	Antivirals, HIV-Spec, Nucleoside Analog, RTI Combinations	All
A	W5M	Antivirals, HIV-Specific, Protease Inhibitor Combinations	All
A	W5O	Antivirals, HIV-Specific, Nucleoside-Nucleotide Analog	All
A	W5Q	ARTV Comb – Nucleoside-Nucleotide Analog & Non-nucleoside RTIS	All
D	W5S	Antivirals, General/Dietary Supplement Combinations	None
A	W5U	Antivirals, HIV-1 Integrase Strand Transfer Inhibitor	All
D	W6A	Drugs To Treat Sepsis Syndrome, Non-Antibiotic	None
D	W7B	Viral/Tumorigenic Vaccines	None
D	W7C	Influenza Virus Vaccines	None
D	W7J	Arthropod-Borne And Other Neurotoxic Virus Vaccines	None
A	W7K	Antisera	All
D	W7L	Gram Positive Cocci Vaccines	None
D	W7M	Gram Negative Bacilli (Non-Enteric) Vaccines	None
D	W7N	Toxin Producing Bacteria Vaccines And Toxoids	None
A	W7S	Antivenins	All
D	W7T	Antigenic Skin Tests	None
D	W7U	Hymenoptera Extracts	None
D	W7W	Miscellaneous Therapeutic Allergenic Extracts	None
D	W7Z	Combination Vaccine And Toxoid Preparations	None
A	W8A	Heavy Metal Antiseptics	All
A	W8B	Surface Active Agents	All
A	W8D	Oxidizing Agents	All
A	W8E	Antiseptics, General	All
A	W8F	Irrigants	All
D	W8G	Miscellaneous Antiseptics	None
D	W8H	Mouthwashes	None
A	W8J	Miscellaneous Antibacterial Agents	All
D	W8T	Preservatives	None
PA	W9A	Ketolides	None
PA	W9C	Rifamycins and Related Derivative Antibiotics	None
PA	W9D	Glycylcyclines	None

Body As A Whole

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	Z1D	Enzyme Replacements (Ubiquitous Enzymes)	None
D	Z1E	Antioxidant Agents	None

Status	TCC	Therapeutic Class Description	Preferred Drug(s)
D	Z1J	Metabolic Dx Enzyme Replacement, Mucopolysaccharidosis	None
A	Z2D	Histamine H2 Receptor Inhibitors *****Effective May 19, 2008*****	Cimetidine Famotidine Nizatidine Ranitidine
PA	Z2E	Immunosuppresives	None
A	Z2F	Mast Cell Stabilizers	Cromolyn Sodium
PA	Z2G	Immunomodulators	None
D	Z2H	Systemic Enzyme Inhibitors	None
D	Z2M	Immunosupp - Monoclon Antibody Inhibiting T Lymph Function	None
A	Z2N	1st Generation Antihistamine-Decongestant Combinations	Brompheniramine/Pseudoephedrine Chlorpheniramine/Pseudoephedrine Triprolidine/Pseudoephedrine
A	Z2O	2nd Generation Antihistamine-Decongestant Combinations	Loratadine/Pseudoephedrine
A	Z2P	Antihistamine – 1st Generation	Hydroxyzine HCl Hydroxyzine Pamoate Cyproheptadine Diphenhydramine Chlorpheniramine Maleate Promethazine
D	Z2R	Leukocyte Adhesion Inhibitors, Alpha 4 Mediated, IGG4K MC AB Type	None
D	Z2T	Histamine H2-Receptor Inhibitor/Dietary Supplement Combinations	None
A	Z4B	Leukotriene Receptor Antagonists	Montelukast (Singulair)
A	Z4E	5-Lipoxygenase Inhibitor	All
D	Z9D	Diagnostic Preparations, OU	None

APPENDIX G
DOCUMENTATION REQUIREMENTS(1)

In addition to the documentation requirements published by the American Medical Association in the Physicians' Current Procedural Terminology book, L&I or Self-Insurer has additional reporting and documentation requirements to adequately manage industrial insurance claims.

L&I or self-insurer may request the following reports. No additional amount is payable for these reports as they are required to support billing. L&I's Report of Accident or the self-insurer's Physician's Initial Report are payable separately. "Narrative report" as used in the table below merely signifies the absence of a specific form. Office/chart notes are expected to be legible and in the SOAP-ER format as specified under **CHARTING FORMAT**. Level of service is based on the documentation of services and the medical/clinical complexity as defined in the CPT Evaluation & Management (E/M) coding requirements.

Service	Code(s)	Requirements
Case Management and Telephone Calls	CPT® 99361-99373	Documentation in the medical record should include: • the date, • the participants and their titles, • the length of the call or visit, • the nature of the call or visit, and • any decisions made during the call.
Chiropractic Care Visit	Local 2050A & 2051A	Office/chart notes
	Local 2052A	Narrative report or office/chart notes showing the increased clinical complexity
Consultation	CPT® 99241-99275	Narrative consultation report (WAC 296-20-051) • due to the insurer within 15 days of consult
Critical Care	CPT® 99291 & 99292	Narrative report or daily chart notes
Emergency Room	CPT® 99281 & 99282	Report of accident and ER report/notes in the hospital medical record.
	CPT® 99283-99285	Report of accident and ER report
Hospital	CPT® 99221-99223	Report of accident and H&P
	CPT® 99231-99238	Narrative report or an interval progress note
Nursing Facility	CPT® 99301-99303	Narrative report or facility notes and orders
	CPT® 99311	Narrative or an interval progress note
	CPT® 99312 & 99313	Narrative report or facility notes and orders
Office Visit	CPT® 99201 & 99202	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99203-99205	Report of accident and office/chart notes due to the insurer in 5 days
	CPT® 99211 & 99212	Office/chart notes
	CPT® 99213-99215	Narrative report or office/chart notes showing the increased level of complexity
Prolonged Services	CPT® 99354-99359	Narrative or office/chart notes showing dates and times
Psychiatric Services	CPT® 90804-90853	Narrative report
Standby	CPT® 99360	Narrative or office/chart notes showing dates and times
Miscellaneous	CPT® 99288 & 99499	Narrative report or emergency transport notes

(1) See WAC 296-20-06101 for any additional information

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- Only items with page numbers can be found within the policy manual.
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- **FEE SCHEDULES** can be found under **Fee Schedules**.
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